AN EVALUATION OF THE EXPERIENCES AND PERCEIVED EFFECTS OF CHILDREN USING A LOCAL SURE START PROGRAMME

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ABSTRACT

At the end of the last century a governmental comprehensive review recognised that changes to children's services in the UK were needed, as existing services were unable to meet the developmental needs of many children particularly those living with disadvantage. Early interventional services and programmes are designed to promote the development of children and research, much of which has been carried out in the USA, has found that the most effective interventions are holistic services able to recognise and meet the needs of communities, families and children. In the UK this knowledge contributed to the creation of Sure Start, a national early interventional programme working to promote the development of children through local agencies set in deprived areas over the whole of the country.

This thesis explores the experiences of children and their families using a local Sure Start programme in Wales, and examines the perceived effects of the programme on the development and developmental environment of the children. The descriptive short-term longitudinal cohort investigation was based in Rhondda Cynon Taff Sure Start, a local programme whose services are available for all families with young children who live in the county. Thirty one families from Rhondda Cynon Taff with thirty four children aged between 3 – 48 months old were recruited to the study, the sample consisted of eight children (25%) from multi-risk families and twenty- six (75%) from lower-risk families.

Complete data sets were obtained for 88% of the sample. The developmental progress and the developmental environments of children were measured over the time of service use using well validated, standardised instruments (ASQ, ASQ:SE, HOME). Family experiences of service use and perceptions of its effects on participant children were explored by narratives elicited by semi-structured interviews conducted with parents before and after service use. The family experiences also were set within the framework of the Developmental Systems Model for Early Intervention to discover whether this model could be profitably used to direct and evaluate the services provided by a Sure Start Local Programme.

The data revealed that lower-risk families were more likely to: use universally available Sure Start activities and services; approach health professionals to request

help when child or family problems arose; engage well in and remain in service use. Multi-risk families were more likely to be referred to Rhondda Cynon Taff Sure Start services to meet concerns identified by health and educational professionals, and less likely remain in service use. Inspection of the individual assessments of participant children showed that Rhondda Cynon Taff Sure Start services could be associated with beneficial impacts on the development of many children from lower-risk families. A statistically significant effect on aspects of lower-risk children's home environments was also demonstrated. Service use was found to be less effective for children from multi-risk families; all multi-risk children left service use with persisting developmental delays and no significant effect on the home environment of these families was identified. This study also supported the use of Children's Centres to provide early intervention services: the provision of Sure Start services over the wide geographical area of Rhondda Cynon Taff did not appear to promote universal local knowledge of services, and made use of the full range of services difficult for some families who were not within walking distance of services.

Application of the Developmental Systems Model for Early Intervention to the experiences of participant families identified areas where changes to the current practices of Sure Start Local programmes, as illustrated by Rhondda Cynon Taff Sure Start, could be beneficial. The process suggested that adherence to the model's framework may increase the programme's ability to recognise and meet the developmental needs of the service users, and also suggested that changes to the early interventional model could increase its ability to guide the process of effective early interventional services, particularly when working with vulnerable or hard to reach families and children.

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AUTHOR'S DECLARATION

I declare that the work in this thesis was carried out in accordance with the regulations of the University of Glamorgan/Prifysgol Morgannwg. The work is original except where acknowledged or indicated by special reference in the text. No point of this thesis has been submitted for any other degree.

Any views expressed are those of the author and in no way represent those of the University of Glamorgan/Prifysgol Morgannwg.

The dissertation has nor been presented to any other University for examination in the United Kingdom or overseas,

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Date .....

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CHAPTER ONE: Introduction: Child Development and Early Intervention

1.1. Introduction

Concern about children living with poverty and disadvantage has existed for many centuries. Since the early 1800's UK reformers have campaigned for national changes, and successive legislation has slowly - with varying degrees of success - addressed issues such as child employment, child poverty, universal child education and child health. Despite this, until recently UK family life was viewed as a private space in which intervention was unusual unless some family crisis occurred (Anning & Ball, 2007). The 1997 UK election gave hope of some change in this, as it brought into power a Labour government who were aware of existing societal disadvantages, and of the fact that many disadvantaged children were repeating their parent's experiences of poverty, ill-health and poor education (Melhuish & Hall, 2007). During the early days of the new Labour government a Comprehensive Spending Review (1998) was carried out, a process which reviewed the services for young children. The resultant report concluded that services in the UK were failing many of the children in greatest need, and pointed to evidence that provision of early interventional services could promote the developmental progress of such children. As a result Sure Start was created in the belief it could positively effect the development, well being and 'school readiness' of many disadvantaged young children.

Sure Start began as a national early intervention programme that worked through local agencies (Sure Start Local Programmes, SSLPs). In order to reach many of the UK's most disadvantaged children, families and communities SSLPs were set up in identified areas of deprivation and charged with working in collaboration with local services, organisations, parents and communities. Their remit was to identify local need and then to work to meet these needs by improving the services, facilities and activities in their area, thus enhancing the opportunities and experiences of resident families and young children. The intent and hope was that the work of Sure Start would ultimately have positive impacts on the development of children living in disadvantaged areas. One condition set by the Government was that there must be strict evaluation of the Sure Start initiative (Melhuish & Hall, 2007).

In England, a National Evaluation of the work of Sure Start (NESS) is being carried out. The NESS is centred in Birkbeck College, University of London, with evaluative findings disseminated via pertinent websites (www.ness.bbk.ac.uk, www.surestart.gov.uk), in academic papers and publications, and through the media. Although Sure Start was

established in England, Northern Ireland, Scotland and Wales, the fact that the devolved countries were not included in the NESS left a need for evaluation of Sure Start work in these areas. This thesis is based on an evaluation of the work of a SSLP in Wales, namely Rhondda Cynon Taff (RCT), a SSLP set in the valleys of South Wales. This chapter will outline the background, aims and overview of the present study, before describing the structure of the thesis.

1.2. The Background of the present study:

For a long time the study of child development centred on arguments about whether human development was predetermined at conception, or affected by experiences and environments encountered in life. In relatively recent times scientific research has led to the belief that genes and environments affect child development in a complex and closely intertwined fashion (Coll, Bearer & Lerner, 2004a).

Experiences, environments or conditions likely to adversely impinge on child development have been identified and termed 'risk factors'. In the 1960's, American concern about the effects of risk factors on the development of their children, especially those living with disadvantage, led to the design and introduction of intervention programmes focused on addressing known risk factors and improving the developmental outcomes of children from poorer backgrounds (Berlin, O'Neal & Brooks- Gunn, 2003). Since then research, some based on these early intervention programmes in the USA, has provided a body of knowledge about the effectiveness of intervention services and some strategies have been identified as being most effective for children at increased biological or environmental risk of developmental difficulties or delays e.g. knowledge that earlier, longer more intensive interventions afford greater impacts on children, that children in families who participate the most actively and regularly in services show the greatest developmental progress, that children in programmes providing direct educational experiences show larger, more enduring benefits than those whose programmes rely on indirect routes such as parent training (Fuligni & Brooks-Gunn, 2003).

In the UK, the election of 'New Labour' in 1997 saw an increase in policies to address poverty, social exclusion, and to improve areas of deprivation. Amongst these initiatives was the formation of Sure Start. As mentioned earlier, a rigorous evaluation of Sure Start is being carried out by the NESS in England. Early findings of the services were

somewhat disappointing (NESS, 2005a) and generated some concern about the reach and effects of Sure Start. An important specific concern was the reach of services to more needy families as results suggested less disadvantaged families in Sure Start areas were gaining more from the services than more needy resident families (Anning & Ball, 2007).

In Wales no national evaluation project exists. RCT in South East Wales is an area containing many of the most deprived electoral divisions in Wales. In line with programme recommendations, Rhondda Cynon Taff Sure Start (RCTSS) was established in 2000, and since then has worked to bring together, integrate and supplement the services for young families and children over the whole county. However RCTSS varies from many other SSLPs as - in recognition of the wide distribution of deprivation within its boundaries – all families living in RCT expecting a baby, or having a young child are eligible for RCTSS services. Some early evaluations of RCTSS (Glossop & Macdonald, 2002; Hayward & Macdonald, 2003) have been carried out and resultant reports contained positive findings e.g. evidence of service user satisfaction, but also anticipated the NESS findings referred to above (NESS, 2005a) as they raised doubts about the reach and effects of RCTSS particularly in relation to families in greatest need. These concerns called for further work to explore more fully the work of RCTSS.

1.3. Research Aims.

This study sought to follow a sample of participants through their use of RCTSS services with the objectives being:

- To describe the developmental contexts of participant children, and discover whether services were reaching those children in RCT at greatest risk of developmental disadvantage and delay
- To gain descriptions of participant families' experiences of service use to establish whether the needs of service users were being recognised and met
- To explore parental perceptions of the development of participant children while associated with RCTSS.
- To identify factors which appeared to mediate or prevent/limit service use

As these aims demanded an exploration of the whole process of RCTSS service use, a suitable framework to guide the study was sought, the aim being:

- To set the experiences of RCTSS service users within its framework and determine whether use of such a model provided a useful tool for guiding and evaluating the work of RCTSS.

1.4. Study Overview

The need to collect data from participant families over the whole experience of service use i.e. before, during and after Sure Start service use, led to this project being designed as a short term longitudinal descriptive cohort study. The data collection phase was set over 24 months to allow families to have extended contact with services, and to facilitate inclusion of families using longer term services such as play groups, or mother and toddler groups. Data collection, using both quantitative and qualitative methods, was conducted in up to three phases over participant's time of service use. This allowed researchers to follow the whole of participant's experiences of service use and to record the development and developmental environment of focus children during their association with service use. Data collection ceased when participant children began statutory school or the data collection phase ended. Full details behind the study design and the specific methods employed can be found in detail in Chapter 5.

1.5. Structure of the thesis.

The thesis is divided into eight chapters. As Sure Start is working with the theory of change the literature review begins by exploring research evidence relating the impact of the environment of a developing organism on its developmental progress. The review begins by considering the combined influences of nature and nurture on development. This section begins by briefly examining relevant animal research that underlies the rest of the review which explores the effects of environmental factors on child development. The final section of this review is concerned with the effects of specific environmental risk factors, and with current knowledge about the particularly damaging effect of multiple risk factors on child development.

The third chapter considers the role that social policy can play in promoting child development, before reviewing research which has explored the impact and efficacy of early intervention programmes. Attention is given to USA early intervention programmes, to the findings of the NESS to date, and to the findings of earlier evaluations of RCTSS.

Chapter four discusses theoretical approaches to child development, argues that a developmental systems approach underlies early intervention programmes such as Sure Start, and maintains that an appropriate developmental systems model or theory would be a useful guide and/or framework for the present study. This discussion leads to an evaluation of the Developmental Systems Model for Early Intervention (DSMEI, Guralnick 2001, 2005), a process which results in its adoption as an appropriate model for this study.

Chapter five considers the research methods employed in this study. The rationale for the selection of a mixed methods approach and a justification of the methods selected to collect the data, is followed by a full description of the study's design and implementation. This chapter concludes with a full description of the methods of quantitative and qualitative analysis.

The results chapter presents the study's findings. This begins with findings about the characteristics of the participant sample, as these promise to inform about the reach of RCTSS to its target population. The following sections contain quantitative and qualitative results concerned with the experiences of participant families using RCTSS and with parent's perceptions of their children's progress while associated with the agency. The subsequent discussion chapter collates the study's findings, relates them to the findings of other early interventional programmes - particularly to those drawn from the NESS - and places them within the framework of Guralnick's DSMEI. This chapter also considers the research limitations of the present study.

In conclusion, Chapter eight makes recommendations for changes in RCTSS service provision and for changes to the DSMEI. The proposed changes may improve the effectiveness of RCTSS and other early intervention agencies and increase the usefulness of the DSMEI become more useful, especially when applied to interventions targeting the most vulnerable and hard to reach families.

CHAPTER TWO: Child Development

2.1. Introduction.

Sure Start's intent is to promote the health and development of children living in disadvantaged areas. This chapter reviews evidence that relates early intervention programmes such as Sure Start to current knowledge about the development of the brain, and to the possible effect that living in disadvantage can have on the development of children. The chapter begins with an outline of the process of human brain development and consideration of the plasticity of the brain. This is followed by a review of the neurobiological research that has contributed to current belief that nurture and nature are integral factors which affect the structure of the brain. As animal research has played a major role in our understanding of the process of early brain development, the next section briefly reviews relevant animal studies before turning to consider, in greater depth, evidence drawn from studies investigating human development. As the intent of this study is to explore Sure Start, an organisation which aims to promote child development by changing the environments of disadvantaged children, the remaining sections concentrate on the influence of environmental factors on child development.

2. 2. Brain development and plasticity:

A discussion of factors which affect the process of brain development and the ultimate structure of the brain can only be considered within the context of typical cerebral development:

> *'Brain development proceeds in overlapping phases: making the brain cells (neurulation and neurogenesis), getting the cells to where they need to be (migration), growing axons and dendrites, which are structures needed to link with other nerve cells (neuronal differentiation and pathfinding), developing synapses or points of communication with other cells (synaptogenesis), refining those synapses (maturation and pruning), and, finally, forming the supportive tissue that surrounds the nerve cells and makes for efficient communication among them*
>
> *Shonkoff and Phillips, 2000, p. 186*

Brain and neural network development are genetically predetermined, species dependent and universal within species, and have been called 'experience expectant' as they are produced in expectation of a species' universal, usual needs. However, genetically determined networks do not continue to exist universally. Lack of neural activity caused by lack of appropriate experience can result in the culling of unused neurones, while additional experiences can trigger neural network growth to encode and structure new, unanticipated information, a process termed 'experience dependent' networking (Black,

1998). It can therefore be seen that brain development, whilst guided by genetic information, is also affected by interaction with the environment. This flexibility has led to use of the phrase brain plasticity, a term which refers to the malleability of the brain.

The question now turns to how long cerebral plasticity continues throughout life. Schore (2001) proposed that a period of rapid brain growth - termed a 'critical ' or 'sensitive' period - is experienced from the final trimester of pregnancy until a child is approximately 24 months of age, a time span which makes this early phase of life a time when energy demands are high, and regular interpersonal experiences necessary for optimal maturation. Other research findings suggest a longer phase of neural growth and adaptation in humans, e.g. the near doubling of neurons found in the cerebral cortex between two and six years of age (Shankle *et al.* 2000), the discovery of 'high activity' cerebral areas which correspond with the emergence of various behaviours throughout the first year of life, and indicate that cerebral maturation persists until 16 –18 years of age (Chugani, 1998). A more recent finding, i.e. that learning new skills causes changes in the anatomical structure of the adult brain, changes which atrophy when the new skill is not maintained, (Draganski *et al.* 2004), suggests neural reorganisation, growth and pruning continues in the mature brain. Collectively, these findings help overturn the longstanding dogma of no postnatal neurogenesis in humans, and point to two crucial aspects of cerebral development which are critical to early intervention programmes such as Sure Start:

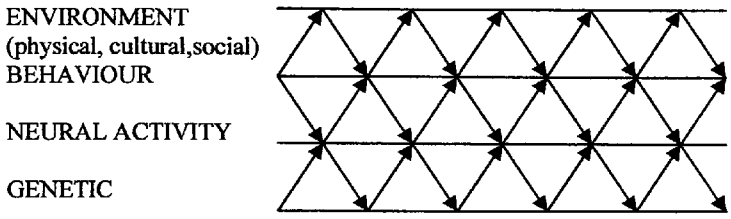
a. Experiences have an effect, especially during 'critical' stages of brain development, which occur during pregnancy and in early life.
b. Brain development and adaptation, and therefore the possibility of effecting developmental changes, continues well into life.

This knowledge promotes the question: how wide are the genetic boundaries set for development, or how flexible is this plastic brain? This appears unanswerable at present as it is asking about the relationship between the genotype and phenotype of an organism. In considering the genetic boundaries of development, although differences in environments and experiences may allow genetic capabilities to be expressed, the extent of 'untapped' genetic potential is, as yet, unknown. Genes have an crucial role in the developmental system, but if - as has been proposed by Gottlieb (2004, cited by Lerner)

and illustrated in figure 1 - genes are but one of a series of components making up a responsive developmental system, with environmental factors providing triggers at different levels which influence other components and signal genetic adaptation, this challenges a trend in biology and psychology to view genes and the environment as contributing separately to phenotypical outcomes, but still leaves the limits of genetic constraints unknown in advance of experimentation or accidents of nature.

Figure 1.

BIDIRECTIONAL INFLUENCES



Probabilistic-epigenetic framework. Depiction of the completely bidirectional and co-actional nature of genetic, neural, behavioural and environmental influences over the course of human development.

Gottleib 2004, p.17

2.3. Environmental influences on development.

Das Gupta (1994) cites the philosopher Kant as an early supporter of the synthesis of the nature: nurture standpoint. His belief was that humans were born with mental structures which although innately able to deal with external input in specific ways, could only build knowledge as the result of environmental experience. Kant viewed experience as the causal or triggering factor which stimulated innate mental structures to order and organise incoming data, and envisaged this mental organisation as beginning at the moment of birth. The evidence presented below suggests that current opinion, whilst agreeing that the interaction of developmental forces affects the structure and function of the human organism, would argue with the idea of experience dependent cerebral functioning beginning at birth, as it is now widely believed that both pre and post natal environments are capable of influencing cerebral structuring and development.

a. Animal research.

Much current knowledge about human brain development is based or built on evidence gained in animal studies. Animal studies demonstrating the influence of early environmental experiences on pre and post natal development are reviewed below. However, whilst evidence from this field is informative and applicable when the mechanisms involved are similar in humans and animals, caution should be exercised when complex brain mechanisms are addressed (Shonkoff & Phillips, 2000).

The experiments of Hubel and Wiesel (e.g. 1972, 1979) gave early findings which suggested that experiences affect development by influencing the structure and functioning of the developing brain. Visual experiences were found to be instrumental in determining the amount of synaptic pruning in the visual cortex of cats, and consequently a determining factor in visual skills and capabilities. An appreciation of how such findings apply to the development of children is evident in a review of the literature on visual plasticity (Celesia, 2005), which while conceding that the molecular and genetic mechanisms which regulate this visual plasticity are still largely unknown, concludes that current knowledge is enough to warrant clinical application for humans as it shows visual plasticity can be manipulated by experience and used to induce beneficial changes in children with visual disorders.

Greater but still limited knowledge of the actual mechanisms of experience dependent changes can be found in research into the effects of stress, anxiety and depression on the structure and functioning of the brain. The experience of stress is associated with increased activity in the hypothalamic-pituitary-adrenal (HPA) axis which triggers a cascade of neuro-chemical changes and results in an increase in levels of cortisol in the brain. Elevated levels of cortisol cause the atrophy of dendrites in the hippocampus, (e.g. Gunnar & Cheatham, 2003; McEwen, 2003), which results in a lessening in the volume and activity of the hippocampus, an area of the brain whose functions include cognition, behaviour, memory (Aisa *et al.* 2006). Studies which manipulated early contact between rat pups and their mothers explored the behavioural effects of stress on the rat pup, and found immediate and long term effects on the behaviours and responses of the pup which endured into adulthood, (Gunnar & Cheatham, 2003). Findings related to the cerebral effects of stress have not been limited to the hippocampus. The amygdala - an area associated with fear, anxiety, and aggression - also appears to be influenced by

experience, e.g. immobilisation stress in rats was found to correspond with increased production of dendrites in the amygdala, as well as with atrophy of the hippocampus, (Vyas *et al.* 2002). Together these findings suggest post natal stressful environments have been associated with: enlargement of the area of the pup's brain associated with fear, anxiety and aggression; atrophy of the area which deals with cognition; early and long-term continuance of negative behavioural effects.

Animal studies have also looked at experiential effects in the prenatal development period. Findings which indicate that exposure to increased cortisol levels during the foetal stage can harm development include: the association of maternal stress during pregnancy with smaller hippocampal volume, with higher cortisol levels, and with behaviours indicative of greater emotionality in rat pups (Coe *et al.* 2003); long term effects of foetal exposure to synthetic glucocorticoids linked with premature onset of diseases associated with aging (Matthews, 2000). On a more positive note, studies have also suggested that the adverse effects of prenatal experiences, can be ameliorated by later intervention: e.g in rats it was found that although prenatal stress was associated with decreased neurogenesis in the hippocampal region, this negative effect could be completely reversed by post-natal infant stimulation (Lemaire *et al.* 2006). In addition, the theory that cerebral development continues well into life has been supported by the finding that neurogenesis in the dentate gyrus occurs in the hippocampal area of adult rat brains (Altman& Bayer, 1990).

Collectively, the above evidence links the early experiences of animals with the development of brain structure(s), with short and long term behaviours and with health status in later life. It can also be argued that the evidence of the remedial effect of later experiences promotes the use of interventions to mitigate the effects of early adverse experiences. A review of experiential effects on cerebral structure proposed that findings associated with animal studies are increasingly applicable to humans:

> *'evidence has been growing to support the view that adult neurogenesis in the dentate gyrus is a feature of all mammalian species including rats, mice, tree shrews, marmosets, macaques, and humans'*
>
> *Gould & Tanapat, 1999, p.1475*

The focus now turns to evidence of experience-dependent effects on the human brain structure and its impact on human child development and behaviours.

b. Human research.

A search of relevant literature showed that much opinion supports the proposal that experience and the environment are also instrumental in shaping and influencing human brain development. Whilst evidence to support this is cited below, it should be noted that an argument does exist that research makes exaggerated claims of the role of early experience on human development, due to the relative dearth of research looking at the everyday experiences of normal people, and the influence of this 'normal' experience on brain function and development (Reid & Belsky, 2002).

i. Prenatal environment.

The effects of adverse biological and environmental factors on pre-natal child development were summarised by Smith *et al* (1998):

> *'Drugs and other harmful substances can reach the embryo through the mothers blood stream, and some can cause gross body or limb abnormalities.....other risk factors include poor maternal nutrition, infectious diseases, exposure to radiation, and possibly maternal stress.'*
>
> *p.24*

Since this statement in 1998, research has led to deeper knowledge about the role of foetal experiences on child development. A review by Hepper (2005) focused on the increasing awareness of the significance and importance of the 38 or so weeks of pregnancy for human development, and concluded that evidence is growing that foetal experiences and behaviours have an important role in human infant development, e.g. high maternal anxiety during pregnancy has been linked with lower mental and motor development levels in children up to the age of two years, and with increased behavioural and emotional problems to the age of four years (O'Connor *et al.* 2002). O'Connor *et al.* (2002) claim their findings link maternal antenatal experiences with postnatal development problems as they:

> *'suggest the antenatal prediction is not mediated by a link between antenatal and postnatal anxiety or depression, but, as in the animal model, is due to a direct causal mechanism operating in the antenatal period*
>
> *O' Connor et al. 2002, p.505*

This claim can and has been criticised for ignoring other possible contributory factors e.g. psychosocial and genetic factors which may moderate associations (Barlow, 2002; Oates, 2002; Rice *et al.* 2007), but what can be drawn from the above findings, criticisms and

comments is the importance of multiple environmental factors in shaping child development and the belief that such factors can be influential before the child is born.

ii. Post natal environments.

> *'From the day of birth, inputs to the child act on existing networks to strengthen, weaken, modify and add to their activities for example, when the child is held and hugged, brain networks are activated and strengthened and firing spreads to associated networks:'*
>
> *Epstein 2001, p.45*

At the time of birth the human brain is still rapidly developing. This suggests the early years are a time during which experiences can have a big effect on brain growth and structure. In relation to the effects of stress, by the time of birth infants possess an HPA system capable of a discriminatory response to stress i.e. more stressful experiences are associated with higher levels of cortisol, (Gunnar *et al.* 1981; Gunnar, 1992). The levels of cortisol have been linked to cerebral function, as by the age of one, children with high levels of salivary cortisol have been found to have disrupted hippocampal activity (Gunnar & Nelson, 1994), while 'normal' babies are found to display decreasing stress responsive levels of cortisol, until the age of 18 months when even relatively major stressors, such as injections, do not produce a reactive increase in cortisol levels (Lewis & Ramsey, 1995). These findings imply that it is young children who live with continual stress who, due to chronic and constant high levels of cortisol, are at risk of atypical neurodevelopment and consequent developmental difficulties. This implication has been supported by studies investigating the effects of child abuse and neglect, whose findings have included reduced cerebral volume (DeBellis *et al.* 1999), hippocampal atrophy, and cognitive impairment in adulthood (Bremner *et al.* 1997).

Research also suggests that long-term outcomes depend upon the age of the child when experiences occur, with younger children being more likely to display greater levels of brain plasticity. In studies of children reared in Romanian state orphanages but relocated into homes in the UK, children fostered or adopted when six or less months of age displayed good progress and developmental 'catch up' with normal children, but older children, although they made some progress, showed persistent cognitive and emotional problems (O'Connor *et al.* 1999). Other insults to the brain can be caused by trauma, poor nutrition, illnesses or conditions, which result in damage to established neural networks. Recovery from such damage is also related to the age at the time of the injury.

Hertz-Pannier *et al.* (2002) performed a late hemispherotomy (complete disconnection of the hemispheres) on a nine year old patient, in an attempt to control intractable epilepsy. Immediately post-operatively, it was found that the operation had caused severe receptive and expressive language problems. A functional MRI scan 18 months later showed a movement of language related neural networks to the right hemisphere during language tasks, and that this new neural network mirrored activity previously displayed in the left hemisphere. The researchers claim that this illustrated,

> *'the great plasticity of the child's brain and the ability of the right hemisphere to take over some expressive language function, even at a relatively late age.'*
>
> *Hertz-Pannier et al. 2002, p.361*

A consideration of the plasticity of the brain in childhood and adult life demands the inclusion of the effects of positive experiences. Findings show the structure of the brain varies with areas of expertise e.g. the area devoted to finger representations is larger in musicians than non musicians, and in Braille readers who use more parts of one or both hands to 'read,' than those who limit use to a few fingers (Eisenberg, 1999). The extension of environmental influences on brain structure into adult life has also been supported by anatomic and electron microscope studies which indicate adult-generated neurones became part of pre-existing neural systems in the hippocampus, neurogenesis that can result in:

> *'the formation of entirely novel neural circuits, and the regulation of this process by neuroendocrine and experiential factors, is likely to represent an important mode of neural plasticity.'*
>
> *Hastings et al. 2001, p.175*

Evidence, such as that cited above, supports the existence of cerebral plasticity from foetal to adult life, and challenges beliefs in a strong, unbreakable link from genes to IQ to poverty and social deviance, (Dickens & Cohen, 2004). This knowledge supports the concept of early intervention programmes – such as Sure Start – as it demands that efforts should be made to ensure that all young children live in good environments that allow them to recognise and develope their genetic potential.

2.4. Environmental developmental influences

Environmental factors are believed to be capable of influencing early child development and are therefore of relevance to early intervention programmes. Just as nature and nurture are visualised as partners in a dynamic responsive developmental system,

children are no longer viewed as passive recipients of experiences and relationships, but as participants in dynamic interactions who have inputs into and are affected by relationships and situations, which therefore can affect developmental outcomes, (Bronfenbrenner, 1979; Belsky, 1984).

A child develops in a complex set of interacting environmental factors emanating from different 'levels' of the society occupied by the child. These levels have been variously termed: material, physiological and social environments (Corrie, 1994); 'macroscopic' factors such as socioeconomic status and 'microscopic' factors related to the family unit (Sameroff *et al.* 1987); and individual, family and community levels, (Jack, 2000). The last categorisation is based on Bronfenbrenner's (1979) concept of the developmental environment, which views different levels of society as nested structures: an innermost setting - often the home, classroom or laboratory - containing the developing child; a 'between settings' level, consisting of the relationships between different innermost settings; wider community levels in which the developing child is affected by but not actually present in; and finally, encompassing all these, the societal or sub-cultural level. Evidence about the relationship of the different levels to the development of children will now be considered.

a. Home and immediate community environment.

Most children's early development occurs in the family home mediated by close relationships and interactions. The experiences of infants are heavily determined by the relationship they develop with their primary carer, a role usually filled by the biological mother, hence 'mother' will be used to refer to a child's main carer. The type of relationship a child has with their mother has been the subject of a body of research, much of which has centred on the dyadic bond or attachment between mother and child. The evidence has led to the belief that a good attachment bond between a baby and its mother is vital to promote good development, and is therefore an area of great importance when promoting a child's optimal development.

The attachment construct was introduced by Bowlby (1969). He argued infant attachment behaviours are an evolutionary, innate primary drive, the purpose of which is to ensure proximity to and thus elicit care behaviours from parents, until the child is capable of

independent care and species propagation. Successful infant attachment gives a secure base from which the child can make satisfactory developmental progression:

> *'Bowlby's theory was concerned mainly with the making and breaking of attachment ties, probably because his experience of working as a child psychiatrist exposed him to the negative consequences for emotional development of severe maternal deprivation, such as long term separation or being orphaned. Nowadays, however, researchers are generally less concerned with whether a child has formed an attachment, since a child who experiences any degree of continuity of care will become attached to the person who provides that care. Research interest now focuses on the quality or security of the attachment relationship.'*
>
> *Meins, 2003, p.155.*

The classification of different quality of attachment types, measured by different behaviours, originally resulted in attachment bonds being divided into three categories: secure attachments; insecure avoidant attachments; and insecure resistant attachments (Ainsworth & Wittig, 1969). Children who possess secure attachments have achieved a healthy balance between mother:child relationships and the environment, these attachments are formed when a child's early needs are met in a sensitive manner. Insecure attachments result when a child receives unsatisfactory responses to innate demands and needs, and are categorised by the type of behaviour the child uses to cope with the negative emotions rising from the unsatisfactory relationship(s). Insecure attachment types have now expanded into the following:

1. An 'insecure avoidant' attachment in which children react by becoming over environmentally focused;
2. An 'insecure resistant' attachment, where the unpleasant emotions held by the child because of poor relationship experiences are displayed by disruptive behaviours, e.g. clinginess, tantrums and anger;
3. An 'insecure-disorganized' attachment, a typology added by Main and Solomon (1986) in which children display conflicting behaviours, a mix of both avoidant and resistant behaviours, to cope with their emotional discomfort are placed.

Schore's review (2001) integrates attachment theory, developmental neuroscience and developmental psychopathology, and contends that attachment theory is a regulatory theory as secure attachments develop when a mother is able to intuitively regulate her child's emotional state by her responses which, over time, produces a child able to respond to, adapt to and cope with stressors. It is therefore argued that environmental

events which influence brain development during the 'critical' period of development in early life are embedded in the transactions of attachment as,

> *'severely compromised attachment histories are thus associated with brain organisations that are inefficient in regulating affecting states and coping with stress, and therefore engender maladaptive infant mental health.'*
>
> *Schore 2001, p.16*

and that early environments influence the experience-dependent maturation of the limbic system. When this is married to the existence of a critical period of cerebral growth in the first two years of life, it suggests that early stress related experiences which result in insecure attachments can contribute to long lasting negative cerebral effects and associated behaviours. This is supported by other findings which associate insecure attachments with failure-to-thrive (Coolbear & Benoit, 1999, Ward *et al.* 2000) and behavioural problems (Pierrehumbart, 2000), whilst secure attachment has been linked with higher communication, cognitive engagement, and mastery of motivation skills (Moss & St-Laurent, 2001).

Attachment has been related to the progress of developmental skills of children in their wider environmental settings i.e. other local wider family and community arenas, because the earliest attachment relationship is important for these further social developments. Infants use early attachment interaction(s) to generate internal working models of behaviour and these models become schematic representations that guide relationships with others, and hence influence other social relationships throughout childhood and well into adulthood. Although causal links are difficult to make, Denham et al (2003) review behaviour in one innermost setting with developments in other settings:

> *'the importance of social competence outcomes should not be underestimated. Along with marking successful development and predicting later well being, social competence is increasingly recognised as vital to school readiness.....more specifically, social-emotional indicators, including positive interactions with teachers, and positive representations of self are derived from attachment relationships. Emotion knowledge, emotion regulation abilities, social skills and non rejected peer status, often predict academic success when other pertinent variables are taken into account.'*
>
> *2003, p.239*

This powerful statement draws attention to the cascade of developmental progression that is started by experiences in the closest environmental level, parenting and early infant experiences. It also argues that interaction at one innermost environment level can influence development in another – in this case preschool education. If events in one

setting are believed to influence events in another, an association or link between the two can be inferred.

b. Links between settings.

Research has found that the early socialisation and emotional development of children impacts on their development progression in other settings. Children from families who express more positive emotions, form peer relationships characterised by pro-social behaviour (Denham & Grout, 1993), whereas those with more negative familial emotion expression are more likely to have peer interactions that involve aggression, (Knutson *et al.* 2004). Thompson and Raikes (2005) suggest secure attachments support children's emotional development, as good attachments promote emotional intelligence through 'mother:child' discussions of emotion. Links of this emotional progress to behavioural and social outcomes have been demonstrated by: Denham *et al.* (2003) who found children who were better at identifying emotions in others showed less aggression in their interactions with peers; Hughes *et al.* (1998) who found children with better emotional understanding had fewer behaviour problems at school; and Fabes *et al.* (2001) who found that children who discussed emotional states were more likely to have successful peer relationships. Further findings, which link the importance of other early and ongoing home experiences of children with other areas of development, can be found in data from the British Household Panel Study which shows maternal educational status predicts their children's academic outcomes (Ermisch & Francesconi, 1997), while the report of an Effective Provision of Pre-school Education project (Sylva *et al.* 2004) associates early educational experiences with success in more formal education.

> *'EPPE shows that one in three children were at risk of developing learning difficulties at the start of preschool, however this fell to one in five by the time they started school. This suggests that preschool can be an effective intervention for the reduction of special needs, especially for the most disadvantaged and vulnerable children'*
>
> *(piii).*

As well linking early experiences with later developmental progression, the EPPE report also emphasised the importance of the quality of interventions as although the number of children at risk of developmental delay was reduced as their experiences altered, child outcomes were positively related to the qualifications of staff and the quality ratings. The report also associated disadvantage with less than optimal development. When planning early intervention programmes appreciation of the breadth of influential developmental

factors is important. Although many of the effects of disadvantage are experienced at individual levels and can be addressed by interventions targeting at family, child and neighbourhood levels, other determining forces that create disadvantage come from other societal levels, at wider community, cultural and/or societal levels.

c. Social and wider community settings.

A good illustration of how the effects of factors beyond a child's immediate setting may effect a child's development can be found in research cited by Bronfenbrenner (1979) which explored the effects of a national societal problem i.e. the American depression of 1929 at a family level (Elder, 1974). Elder compared the effects of the depression between families who experienced significant income losses during this period. Short term effects included individual effects in the emotional distress experienced by parents and children which impacted on the family's immediate environment e.g. fathers in families most affected by the depression felt their status had been lowered due to the economic hardship caused by unemployment and low income. Children from deprived families identified more strongly with their peer groups, but at the same time performed increased amounts of chores around the house, and became more self reliant. Elder concluded that the depression affected children in many ways e.g. by orientating older boys towards employment and adult responsibilities; giving older boys a desire to excel during the period of deprivation; making girls from similar deprived backgrounds engage more in maternal behaviours, being less likely to enter college; and to give up work when they married or had children.

Cultural situations can also impact on the experiences and opportunities of children, e.g. the caste system creates marginalised groups within societies, a practice which, in India, is linked to high poverty rates, low literacy rates and poor occupational mobility in member and communities of low castes (Corrie, 1994). The effect of changes at community and cultural level was demonstrated in the addressing of caste inequalities by actions at individual and community levels in one area of India. Corrie attributed the better health and educational status of the marginalised caste in one area to increasing awareness of inequalities and to the high political mobilisation of the lower caste community which led to high, quick utilisation of health services, and the provision and use of educational opportunities provided by the provision of better quality schools.

These studies demonstrate how factors emanated from different societal levels can impact on individuals and families, through influencing factors from different levels, i.e. family poverty, parental unemployment, emotional effects, changes in family roles, social exclusion, community awareness. This draws attention to the possible effect of changes at a community and social levels on the lives and development of individuals, and supports the provision of intervention services on a wide national level which are capable of targeting cultural, community and individual levels, especially to address problems in disadvantaged or socially excluded areas such as those areas selected for SSLPs..

2.5. Developmental risk factors.

Research, such as that cited above, which increases understanding of the role of environmental influences on child development is vital as new or improved knowledge can be used to improve environments, and help achieve better developmental outcomes for children particularly those living in disadvantaged environments. This, of course, is the aim of Sure Start. Research has helped identify factors within the environmental levels surrounding a child that may adversely impinge on the child's development. These have been termed 'risk factors,' i.e. situations, events or experiences which do not inevitably lead to developmental problems but increase an individual's vulnerability to developmental problems, particularly when they accumulate and interact (Balbernie, 2002). This section begins by considering specific risk factors believed to affect child development before reviewing findings focused on the cumulative effect of multiple risk factors.

a. Individual developmental risk factors:

Factors believed to impact on the development of children can be found in Table 1. In the light of the present study, the following consideration will be limited to factors which can be addressed by interventions provided by an early intervention programme. This approach includes all factors from the 'Environmental' and 'medical and environmental' columns as well as factors in the 'Medical factors' column which can be affected by changes in the child or families' environment. Discussion will be divided into factors in ante, peri, and post natal stages of child development, but some factors can impact and have effect in more than one setting or stage of life.

Table 1: Developmental risk factors.

Medical risk factors	Environmental	Medical & Environment
Ante/peri natal: Intracranial haemorrhage. Perinatal asphyxia. Neonatal seizures. Small for gestational age. Birth weight< 2500 grams. Ventilation > 72 hours. Hyperbilirubinemia. Central nervous system infection. Congenital infection . Congenital defect. Hydrocephalus. Multiple minor physical anomalies. Abnormal neuromotor examination results at time of nursery discharge. Maternal phenylketonuria or acquired immunodeficiency syndrome. Gestational age < 34 weeks. Aspirational pneumonia. Family history hearing loss. **Postnatal:** Non-febrile convulsions. Failure-to-thrive or paediatric under nutrition. Recurrent apnoea. Chronic illness. Chronic otitis media	Caregiver interaction considered risk. Parents with disabilities or limited resources. Low income. Low parental education. Atypical or recurrent child accident. Disturbed family interaction. Lack of stable residence. Family with 4 or more preschool age children. Parents with developmental history of loss or abuse. Parent-child separation. Physical or social isolation and or inadequate social support. Head injury with loss of consciousness. Central nervous system infection.	Maternal age 19 or younger. Maternal substance abuse. No or limited antenatal care. Inadequate family health care. Parent with severe chronic illness. Parent with substance dependence.

adapted from Squires et al 1999, p.33

i Ante- natal risk factors.

From the moment of conception until the moment of birth, a human child develops inside its mother. The immediate environment of the developing infant is therefore dependant upon the physiology and environment of its host, i.e. the health and well-being of the mother.

In relation to the mental health of the mother, possible effects of maternal stress on development of the foetus *in utero* were discussed earlier (1.3.b). Further evidence to support the theory that maternal mental health can affect the development of the infant is available, e.g. Diego *et al.* (2005) found that neonates born to mothers depressed during the pregnancy spent more time crying and exhibiting stress behaviours than did the newborns of mothers who did not experience depression while pregnant, and O'Connor

et al. (2007) found higher levels of pre-natal maternal anxiety and depression predicted persistent sleep problems in infants from age 6 months through until 30 months old.

The physical health of the mother can also impact on the development of the foetus. Preventative interventions, such as Rubella immunisations, have been based on knowledge about the detrimental effects of a pregnant mother's illness on the development of her baby. However other aspects of a mother's health e.g. maternal nutrition or substance use, can also lead to problems during the ante-natal development of the child. Good nutrition engenders optimal brain and tissue development (Georgieff & Rao, 1999) e.g. adequate amounts of iron are needed for foetal red blood cell and neurological development (Judge *et al.* 1997); administration of iodine to the mother in the second trimester of pregnancy improves the neurological and psychological development of the children an effect not found when iodine was administered during the last third of pregnancy (Cao *et al.* 1994); nutritional deprivation in the second trimester resulted in insufficient production of neurons whilst later antenatal maternal nutritional deprivation affected the number of glial cells and the maturation of the neuron (Dickerson *et al.* 1981). Such findings show that adequate nutrition throughout pregnancy promotes the optimal development of children in the foetal stage, but the full role of multiple nutrients is still unknown:

> *'Iodine deficiency during pregnancy has negative and irreversible effects on the developing fetus. Although there is some evidence that postnatal iodine deficiency is associated with cognitive deficit, the findings are controversial. Iron deficiency is widespread and has been linked to cognitive deficits, but the results of prevention trials are inconsistent. Zinc deficiency has been linked with low activity and depressed motor development among the most vulnerable children.....Although micronutrient deficiencies often co-occur in the context of poverty, little is known about the impact of multiple micronutrient deficiencies on cognitive development'*
>
> *Black, 2003, p.3927S*

Other work has concentrated on the risk that maternal use of toxic substances poses for antenatal child development. Many research studies are related to one of three substances i.e. tobacco, alcohol or other drugs. Ante-natal maternal use of nicotine has been linked to adverse effects on the foetus, which include low birth weight, pre-mature birth, intrauterine growth retardation, cot-death, still birth and spontaneous abortion (Storm *et al.* 1999, Trotter & Montague, 2004). Restricted foetal growth or low birth weight,

caused by foetal nicotine exposure, premature birth or decreased oxygen availability are associated with later adverse lung function and respiratory health in the exposed child, exemplified by increased incidence of later respiratory illnesses and an increase in the rate of lung aging (Maritz *et al.* 2007). Pre-natal maternal smoking has also been associated with subsequent child obesity (Power & Jefferis, 2002), and with increased risk of Attention Deficit Hyperactivity Disorder (Markussen-Linnet *et al.* 2003).

Maternal antenatal alcohol use interferes with the development of the brain and adverse child outcomes can vary from subtle functional effects to foetal alcohol syndrome. Research has linked maternal antenatal alcohol use to enduring cognitive and behavioural problems (Olson *et al.* 2000, Howell *et al.* 2006); problems in children's social skills (Kelly *et al.* 2000); persistent adverse effects on fine motor and balance (Connor *et al,* 2006); long term antisocial behaviour (Steinhausen *et al.* 2003), and with increased delinquency in adolescence (Schonfeld *et al.* 2005). Further detrimental effects of antenatal alcohol use on the health of the children of mothers who drink while pregnant have been demonstrated by Gauthier *et al.* (2005), who associated excessive maternal alcohol use with increased risk of infections in newborn infants.

Research into the effects of ante-natal illicit drug use on the developing foetus found that Neonatal Abstinence Syndrome occurs in up to 80% of pre-natally opiate exposed children, which results in irritability, difficulty in feeding, and caring difficulties in newborn infants (Niar *et al.* 2003). Conflicting results can be found in the findings of studies looking at the longer term effects of prenatal exposure to illicit drugs. A review of studies investigating the effects of pre-natal cocaine exposure on infant physical growth, developmental test scores, and language skills (Frank *et al.* 2001) concluded that many findings previously attributed to cocaine exposure correlated with other factors such as pre-natal exposure to tobacco, cannabis, alcohol and the child's post natal environment. However other study findings suggest that the cocaine is specifically associated with developmental problems as 'cocaine-exposed' low birth weight infants suffered persistent cognitive, social and emotional delays (Singer *et al.* 2001a), and were small for gestational age and microcephalic (Singer *et al.* 2001b) when compared to a control group without cocaine-exposure. Anthony *et al,* (2004), investigated the effects of different amounts of pre-natal cocaine exposure on development delays, and found it was children pre-natally exposed to greater amounts of cocaine who displayed deficits in later

language performance. When considering the effects of other substances, Lindfelt (2004) concluded that pre-natal drug exposure impacted negatively on children's social development, while Gray *et al.* (2005) extended knowledge to the timing of foetal drug exposure, with the finding that use of cannabis in the first and last trimesters of pregnancy predicted depression in children at the age of ten years old.

Having reviewed some effects of antenatal maternal physical and mental health, attention turns to other risk factors which can affect the progress of the child during the ante-natal phase. Teenage pregnancy has been linked to complications during pregnancy e.g. late foetal death and increased rates of infant mortality (Olausson *et al.* 1999; Chahande *et al.* 2002; Phipps & Sowers, 2002), premature birth (Scholl *et al,* 1994; Lao, 1997), and low birth weight (Botting *et al.* 1998). Studies suggest it is very young mothers i.e. those aged fifteen or under, who are most vulnerable to complications such as infant mortality, very low birth weight and very preterm deliveries (Phipps & Sowers, 2002; Reichman & Pagnini, 2002). Teenage pregnancy has also been linked to an increased risk of post neonatal infant death (Markovitch *et al.* 2005). Markovitch *et al.* associate this increased risk with additional socioeconomic factors, a view supported by a report published by the World Health Organisation (2006) which links teenage pregnancy to later poor socio economic status, low maternal educational attainment, maternal mental health difficulties, and maternal drug problems, all socio-economic factors which will be returned to later.

Young motherhood has also been associated with poor use of antenatal care (Blondel *et al.*1993), a practice linked to poor pregnancy outcomes. Women with inadequate antenatal care are more likely to have a child showing intrauterine growth retardation (Blondel & Marshall, 1998; Coria-Soto *et al.* 1996; Joseph, 1989), and to have a preterm delivery (Coria-Soto *et al.* 1996; Kreuger & Schon, 2000). Inadequate ante-natal care does not necessarily mean fewer antenatal visits as research suggests other socio-economic factors contribute to the eventual outcome, i.e. fewer ante-natal visits for women with low risk pregnancies does not affect maternal or child outcomes (McDuffle *et al.* 1996; Carroli *et al.* 2001), but pregnant women who attend few ante natal appointments and have other risk factors such as poverty, young age, being multiparous, or substance abusers are more likely to experience premature birth, low birth weight, low APGAR scores at birth, or peri-natal infant death, (Blondel *et al.* 1993; Blondell & Marshall, 1996; Delvaux *et al,* 2001; Petroux *et al.* 2003; Humphrey & Keating, 2004).

The difficulty of dissociating influential factors becomes apparent with the realisation that peri-natal risk factors such as low birth weight and premature birth often arise from adverse ante-natal experiences, which in turn are associated with wider demographic factors.

ii. Peri- natal risk factors.

Peri-natal risk factors that are likely to adversely affect the immediate and later development of the child include the gestational age of the child at delivery, and low birth weights of infants. In relation to low birth weights a developmental distinction exists between LBW babies – who weigh less than 2500 grams at birth - and VLBW children – those less than 1500 grams on delivery

Premature infants are those born before 37 weeks of gestation. Children born early are at a higher risk of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotising enterocolitis, and neonatal sepsis, as well as later motor and sensory impairment, learning difficulties and behavioural problems (Petrou, 2005). The effect of pre-maturity on developmental outcome is related to its extent, with an extremely pre-term child (twenty four weeks) at greater risk than an infant born at twenty-six weeks who, in turn, has a better prognosis than twenty eight weeks (Shonkoff & Phillips, 2000), the earlier a child is born, the more likely it is to have a low birth weight (LBW). LBW, can be associated with premature birth or with poor intra-uterine development, and has been attributed to genetic, demographic, psychosocial, obstetric, and nutritional factors, to maternal morbidity during pregnancy, foetal toxic exposure and to poor antenatal care. In developed countries the most important influential factors are cigarette smoking, poor maternal nutrition, and low pre-pregnancy weight (Copper *et al.* 1996). In recent years interest has extended to the influence of factors such as depression and anxiety on low birth weight, with some findings suggesting these psychological factors have no effect on outcomes (Andersson *et al.* 2004; Berle *et al.* 2005), whilst others suggest they need to co-exist with other factors such as low pre-pregnancy maternal weight, to increase the risk of infant LBW and pre-maturity, (Neggers *et al.* 2006). LBW children carry varying degrees of medical and social risk, including problems in cognition, attention and neuro-motor functioning (Hack *et al.* 1995, Hack *et al.* 2002).

VLBW children tend to have a much lower quality of life, with more health problems, poorer lung, appetite and motor functions and increased levels of anxiety than children of higher weights (McCormick *et al.* 1992). A gradient relationship has also been demonstrated between IQ levels and birth weight, with greatest deficits found in VLBW infants (Breslau *et al.* 1994), a relationship which continues well into the normal birth weight range, (Matte *et al.* 2001). Overall, research suggests VLWB children bear the major developmental disadvantage (e.g. Pharoah *et al.* 2003, Weindrich *et al.* 2003) with deficits mostly attributed to differences in cognitive abilities (McCarton, 1997; Breslau *et al.* 2001). Although 95% of children born after 28 weeks of pregnancy survive, these babies cannot be assumed to have caught up with peers by 2-3 years of age (de Haan *et al.* 2000) whose research suggested cognitive problems associated with premature birth endures. However, Saavalainen *et al.* (2006) suggest some deficits may disappear by the age of 16, as the longitudinal assessments of verbal skills employed in their study demonstrated enduring problems at the age of 9, which had disappeared by age 16. However, the fact that many participant children were lost to the study by age 16 and that those retained had mothers with higher educational levels, calls for further research in this area.

The evidence discussed above shows that risk factors experienced by a child before and/or at birth can have had developmental impact(s) by the time of birth. But obviously, a child continues to develop and be influenced by factors encountered in early life.

iii. Post-natal factors.

As discussed in section 1.3.b, the development of the brain in the first years of a child's life continues apace, shaped by early life experiences. Early experiences usually take place within a family in a family home, a setting affected by different factors.

The structure of the family can be a determining developmental force, but the opinion about specific factors which produce effects has changed over the last decades. Early studies indicated that children in small families progressed better intellectually (Pulvino & Lupton 1978; Wagner *et al.* 1985), whilst others attributed better academic success to birth position, as firstborns from medium and larger families were found to show better intellectual development than later born children (Pulvino & Lupton, 1978). More recently these conclusions - which were drawn from within-family data - have been

criticised, and further work carried out with between-family data (Rodgers *et al.* 2000). Their findings suggest that the lower IQs found in children from large families are associated with the lower IQ of parents not with the size of the families, although the authors are careful not to make nurture or nature causal attributions:

> *IQ is passed on to their children through either genetic or environmental processes(or interactions between the two).*
>
> *Rodgers et al.2000, p.602*

Regardless of the number and spacing of children in a family, the relationship of children's biological parents is important as it affects the environmental atmosphere in the family home and may determine the make up of the family a child lives in. A body of research has shown that families in which parents have separated, (non-intact families), are more likely to have children with behavioural problems (e.g. McCulloch *et al.* 2000), who achieve less academically (Scott, 2004). Adverse effects on children have been attributed to experiences before the parental break-up as the split is often preceded by difficult family relationships in unsupportive, conflictive home environments which are more likely to produce children with emotional and social problems (Repetti *et al.* 2002; Diener & Do-Young, 2003). In discussing children's outcomes after family difficulties and conflicts, Buchanon and Brinke (1998) point out that while family restructuring may be a positive step if breakdowns are caused by violence, the fact remains that 80% of families in touch with social services in the UK are lone or step families, which implies family break-ups and/or restructuring or blending are associated with problems which increase the need for and likelihood of intervention from outside agencies. In a review of the quality of parenting and child development, Golombok (2004) maintains studies have consistently shown that children brought up by single mothers are more likely to show psychological problems, and to perform less well at school when compared to children in two parent families. She continues to itemise contributory factors associated with single parenthood, e.g. poverty, lack of social support, conflict in parental relationships, poorer parenting skills, and less supervision of children, maternal depression, and concludes this evidence has led to the belief that the negative effect of single parenthood on the development of children is not due to lack of father contact, but because of associated factors which come with single parenthood. This supports the hypothesis of Ricciuti (1999) that single parenthood itself is not related to adverse child outcomes, as other parental and family factors are often found co-existing in single parent families.

A child's early developmental environment and experiences are influenced by a child's parent's characteristics, their practices and attitudes. Parental relationship problems were mentioned earlier, but other factors such as parental mental health problems, substance abuse, illness, disability, education levels, as well as physical or social isolation can adversely affect parental capabilities and ultimately influence the developmental progression and outcomes of their children. Parental mental illness can affect attachment formation, the cognitive, emotional, social and behavioural development of children, and can put children at risk of developing psychiatric problems throughout life (Manning & Gregoire, 2006). A meta-analysis of 33 studies investigating the relationship between maternal depression and behavioural problems in children (Beck, 1999) showed a moderate relationship between maternal depression and child behaviour problems, a finding which persisted when results were divided into preschool and school age children. Maternal depression has also been linked to mental health problems in adolescent offspring (Halligan *et al.* 2007, Spence *et al.* 2002). A possible explanation has been provided by Jennings and Abrew (2004), who found the children of depressed mothers possessed lower self efficacy than those of non-depressed mothers, and attributed this to maternal modelling, to less maternal encouragement of the children's efforts as well as to biological contributions. As low self-efficacy is a key component of depression this finding is a possible link to later mental health problems.

In relation to cognitive development and early experiences, Farah *et al.* (2005) found children's language abilities were predicted by cognitive stimulation, and their memory skills linked to social/emotional nurturance. As maternal depression has been associated with diminished parenting behaviours (Kavenaugh *et al.* 2006), these findings may contribute to better understanding of the poor developmental outcomes of children of depressed parents. Ongoing parental substance abuse can have a negative impact on child development by diminishing parental practices and affecting the care they provide for their children, e.g. maternal alcohol abuse has been linked to insecure attachments and depression in child offspring (Edwards *et al.* 2001; Olsen *et al.* 2001), maternal alcohol and drug abusers have been found to be more punitive than non using control groups (Hans *et al.* 1999; Miller, 1999), whilst substance misusing parents possess poorer parenting knowledge (Velez *et al.* 2004). Maternal abuse of substances occurs before and after child birth, a circumstance which can lead to argument about the relative effects of the timing of such practices on child development. Some research has 'sidestepped' this

debate by looking at the effects of paternal substance abuse, research which has produced findings which attribute internalising infant behaviours at 12 months to paternal alcoholism (Edwards *et al.* 2001), but it could be argued that maternal stress caused by partner alcohol abuse could have affected the pre and post natal environment and development of the infant. However, post natal environmental factors have been found to moderate effects of maternal substance abuse, Ornoy *et al.* (2001) found children born to mothers with heroin addiction had higher rates of ADHD than the children of non-using mothers, and furthermore the children of addicted mothers who were adopted early in life demonstrated lower incidences of ADHD than those who remained with their biological mothers. Although this study provides interesting findings and appears to support the hypothesis that changes in the early environment of a child mediates changes in developmental progression, it fails to isolate exactly which changes are associated with the behavioural improvements and to fully acknowledge the fact that changes in other factors facilitated by adoption may effect change, for example;

1. An adoption may involve change in the area of residence. A neighbourhood effect has been found in which children living in deprived areas had lower cognitive scores and higher behavioural problems, (Danseco & Holden, 1998; McCulloch, 2001, 2006) a finding which may be contributed to by factors such as increased exposure to noxious substances such as lead exposure which are found at elevated levels in neglected, decaying housing (Wasserman & Factor- Litvak, 2001),
2. The adoptive parents may hold different parental attitudes, beliefs and characteristics, which are linked to the developmental progress of children (Leibham *et al*, 2005; Hao & Matsueda, 2006), while better maternal education is linked to children's better reading skills and language skills (McCulloch, 2001; Raikes *et al*, 2006; Umek 2006) and better quality of child-care predicts better cognitive and language skills in children, (Oxford & Speiker, 2006),
3. The new family may provide better nutrition and health practices. Inadequate nutrition may predict developmental problems such as overweight in childhood (Dubois *et al.* 2006) or, as illustrated by Lozoff *et al.* (1996) infant anaemia which is associated with lower mental test scores.

Although this review has considered many possible individual risk factors e.g. maternal mental and physical health, parental misuse of substances, age of mother, poor use of antenatal care, prematurity and low birth weight, aspects of the structure of the family,

parental intelligence, parental education, area of family residence, the section also illustrated the difficulty of distinguishing single risk factors from the many possible contributing factors. This problem has been commented on in many research reports e.g. Wasserman & Factor- Litvak, 2001; Balbernie, 2002; McCulloch, 2006. The next section considers the occurrence and impact of multiple risk factors on child development.

b. Multiple risk factors

The UK Governmental Green Paper *'Every Child Matters'* (DfES, 2003) associates poor outcomes for children in Britain with

- Low income
- Parental unemployment
- Homelessness
- Poor parenting
- Substance misuse
- Low Birth Weight
- Community factors

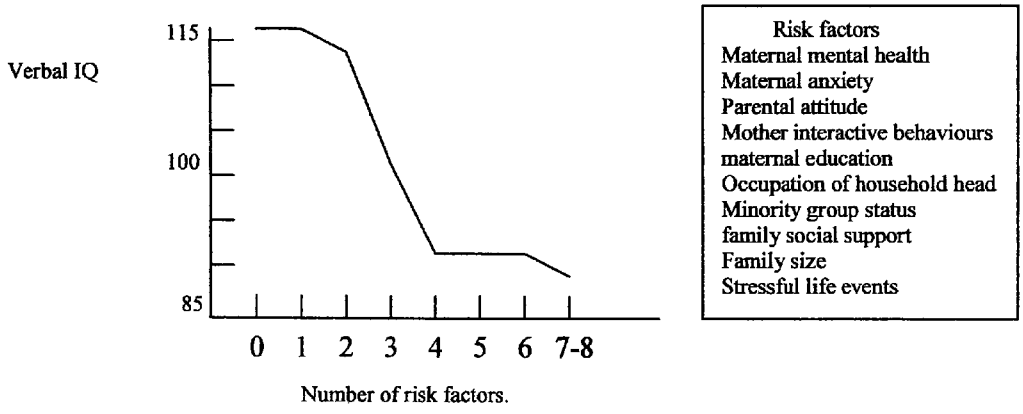
These factors quickly became familiar when reviewing relevant literature, and have been cited by many other interested researchers, although some have added to the above list or broken factors into more specific ones e.g. domestic violence, family size and family structure (Nair *et al.* 2003), mental illness and anxiety, parental education, minority status, social support, stressful events (Sameroff, 1998), sexual abuse and criminal behaviour (Amaro *et al.* 1990), intergenerational transmission (Reading, 2004).

Research studies have explored risk factors with the hope of finding more about the causes and mechanisms of different child developmental outcomes. It appears an important conclusion has been reached as stated by Sameroff (1998):

> 'At the end of 4 years of development, we had discovered the effects of multiple risk factors. On one hand, if the only developmental risk for a child was a mother with an emotional problem or who lacked social support or had a low educational level, usually the child was doing fine. On the other hand, if the child had a mother who was mentally ill and poor and uneducated and without social supports, that child was doing poorly. What we learned was the overriding importance of attending to the combination of environmental adversity with the social context of the child to understand their development. P.1228

This hypothesis has been supported by much research (e.g Rutter, 1979; Riccuiti, 1999; Nair et al, 2003; Golombok, 2004; Oxford et al, 2006,). Sameroff et al (1987) also investigated whether it was the type or number of co-existing risk factors that predicted effect on early intelligence. The study tested children at age four years old, and found that as the number of risk factors increased the verbal IQ score of children deteriorated, with the biggest difference in scores occurring between 2 and four risk factors (Fig.2).

Figure 2: Means of 4-year-old children's verbal IQ scores for each accumulative risk score. Cumulative risk scores are totals of high risk factors present in each child's family.



Sameroff *et al,* 1987, p.347

Poverty has been cited as a powerful risk factor because of it's association with detrimental influences on children's development (McLoyd, 1998). This strongly links socioeconomic disadvantage with child developmental outcomes, an opinion supported in many discussions and research reports citing evidence that found:

a. Families living in poverty are likely to be living with multiple risk factors, (e.g. McLoyd, 1998; Duncan & Brooks-Gunn, 2000; Reading, 2004; Farah et al, 2005),
b. Poverty or low income is adversely associated with children's cognitive development, achievement and behaviour in preschool, an association which increases in the early school years, and leads to higher incidences of dropping out of later education (Brooks-Gunn, 2003).
c. The evidence from many countries persistently shows that children who grow up in poverty are more vulnerable, specifically: they are more likely to be in poor health, to have learning and behavioural difficulties, to underachieve at

school, to become pregnant at too early an age, to have lower skills and aspirations, to be low paid, unemployed, and welfare dependent, (UNICEF, 2007).

i Poverty in the UK

The 'Poverty and Social Exclusion Survey of Britain' (ONS, 1999) found the proportion of households living in poverty in the UK had increased from 14% in 1983 to more than 24% in 1999. The impact of this on children has been shown in an increase in numbers of children living in poverty from 1.4 million in 1968 to 4.3 million in 1996, (Gregg et al, 1999). A link of unemployment with child poverty can be discerned, as almost half the poor children of 1996 lived in workless households. The increased risk of families with children living in poverty has been a relatively long term problem, as by 1999 child poverty rates had been higher than the 'all persons' poverty rate since the mid seventies (Hill & Jenkins, 1999). Using the British average income, the pattern over relatively recent times has been of a clear decline in overall poverty rates from the late sixties to 1996, but an unprecedented growth in income inequality which has contributed to the doubling of child poverty rates during this time. It can be concluded that, although overall incomes and standards of living may have improved in relation to earlier times, the difference between income levels and living standards within society had become wider since the 1970's, especially for families with children and without a working family member. Furthermore, Hill and Jenkins demonstrated that employment in itself did not remove families from poverty, as the vast majority of poor working families were receiving pay from the lowest quartile of the overall earnings distribution.

As well as considering the effects of unemployment and low pay, Gregg *et al,* (1999) found the number of single parent households had risen from 6% to 22% between 1968 and 1996, and that 65% of these single parent households were poor. The theory that the incidence of poverty is associated with changing structures of households is supported by an investigation into the patterns of child income poverty in 25 industrialised nations which included the UK, (Bradbury & Markus, 1999). Their analysis showed that in 1995, 1 in 5 UK children were living in poverty, as measured by the common poverty line, and the UK shared the most dramatic increases in child poverty with Russia, Hungary and Italy. The authors attributed increases in child poverty levels to labour market deterioration and family structure changes. Piachaud and Sutherland (2000) claim child

poverty affects many types of families, and that public perception that child poverty is only associated with single parents, young parents and ethnic minorities is misleading, as over half of children living in poverty at this time had parents over 30, and 80% were from non ethnic minorities. Whilst acknowledging this, certain families are more likely to live in poverty namely families with:

- Four or more children (73%)
- Mothers aged 16-24 (68%)
- Ethnic minority (65%)
- A never married lone parent (79%)
- Divorced or separated lone parent (66%)
- No working parent (86%)

Department of Social Security 1999a

Further confirmation, if needed, that multiple factors, which can arise from economic, cultural, family and/or individual levels, may contribute to the risk of living in poverty. The effect of recent changes in social policy, under the 'New Labour' government of the UK since 1997 will be discussed in the next chapter.

2.6. Conclusion

This chapter began by considering the combined roles of nature and nurture in child development before attention was given to the role of nurturing or environmental forces in influencing early brain development. The compelling evidence drawn from both animal and human studies led to current opinion i.e. that the early developmental progress of humans is influenced by the interplay between both biological and environmental forces. The review then turned to evidence about the effect of the role of adverse or risk factors on children's developmental progression. Evidence that different societal levels can contain varied developmental risk factors all of which can impact on the development of the developing child, either directly or due to a 'knock on' or systems effect in which a movement of one part of a system causes changes or movement in another, was presented. Attention then turned to relevant development factors which can exist in these developmental systems. This began with evidence about pertinent individual factors but led to discussion of the difficulty of dissociating single risk factors, and the fact that in current times many children live with numerous adverse risk factors.

This led to consideration of evidence that it is the number of risk factors a developing child lives with that increases the possibility of experiencing developmental problems and/or delays, and to evidence and opinion that multiple developmental risk factors are likely to be more concentrated in areas of deprivation and poverty.

In summary, research suggests that environmental risk factors can negatively impact on child development, but that negative effects can be ameliorated with appropriate and timely interventions. The probability of child developmental problems and delays rises with the number of developmental risk factors a child lives with, and high numbers of risk factors are more likely to be associated with living in poverty. The conclusion from such evidence is that if the development of children in a society is being negatively affected by the environments they live in and the experiences they are receiving, positive action to improve their environments could promote better development. This provides the underlying rationale for early intervention programmes such as Sure Start. The next chapter will turn to the role of governments and social policy in alleviating adverse developmental risk environmental factors, and to evidence that early intervention programmes can have positive impacts upon the development of disadvantaged children. The development, aims and evaluation of Sure Start to date will then be discussed before consideration turns to the subject of the present study i.e. the work of RCTSS.

CHAPTER THREE: Social Policy and Child Development.

3.1. Introduction.

The last chapter reviewed evidence that early human life is a time when developmental factors can exert strong effects and that these development factors can emanate from multiple, different environment levels. The chapter also considered how developmental risk factors can impact on different areas of development e.g.:

- Health e.g. through poor health service utilisation, substance dependence, or the existence of parental or child health problems,
- Educational development, skills which can be affected by maternal levels of education and the quality of child care,
- Social factors, as illustrated by difficulties associated with poor living conditions, and/or in deprived or socially isolated areas,
- Economic influences on development, particularly the effects of living in poverty.

Social actions/changes can affect these risk factors and are therefore able to influence people's lives and development. Debate about whether the responsibility for this lies with individual citizens or with governmental bodies can be found in popular media referrals to the 'nanny state' and in the different principles and policies of UK political parties. The use of social policy and legislation to address societal needs changes with the beliefs, ideals, priorities and practices of community and national governing bodies:

> *'All of us live in some form of social and economic system. There is growing evidence that it is the system or social and economic structure that affects the way we live and work'* *Macdonald 2000, p.6*

This chapter is concerned with the role, influence and action of social policies on the environments and experiences of individuals, particularly on the development of children. A definition of social policy is followed by brief overview of the history of social policy in the UK, a section which emphasises earlier policies which affected the income and lives of families and children. Discussion then turns to the work of the 'New Labour' UK government, to the policies they implemented to address the needs of disadvantaged individuals and communities, and most specifically to improve the development of children living with disadvantage. This demands a review of knowledge gained from earlier child intervention programmes, and turns attention to programmes implemented in the USA in the second half of the twentieth century. The focus then returns to UK policy and to 'Sure Start', an evidence based UK child early intervention programme set up in 1999. After reviewing the purpose, intent and organisation of Sure Start and published

findings of English national and local Sure Start evaluations, attention will turn to Wales. This section will consider some of the Welsh policies which affect children and young people living in the principality, and to the role of Sure Start in Wales. The final section discusses Rhondda Cynon Taff (RCT) in South Wales and RCT Sure Start, the local agency being evaluated in the present study.

3.2. UK Social Policy.

The field of Social Policy is concerned with the role of the state in determining the welfare of its citizens, whilst social policies are used by governments to change or influence the conditions under which people in their country live. An illustration of how social policy can affect society can be found in the history of the public health reforms in the UK during the nineteenth century. Rapid urbanisation resulted in huge increases in levels of disease and death, partially due to inadequate housing, poor sanitation and the consequent existence of infected water. Health reforms and policies, e.g. the 1848 Public Health Act, encouraged better sanitation, thus improving living conditions and hygiene. This had a larger effect on the health of the UK population than many medical advances and was instrumental in decreasing instances of illness and death (Blakemore, 2001). It can be argued that the growth of the current UK welfare state took root in the nineteenth century.

a. The Growth of a Welfare State.

During the 1800's concern about poverty, child labour and education led to a series of legislative acts e.g. the Factory Act of 1833 which addressed child employment exploitation, reformation of the Poor Laws (1834) which aimed to ensure basic provision for 'deserving' poor such as widows, orphans, or the chronically sick and, in the early 1870's, the introduction of free elementary education up to the age of 12 (Spicker, 2006). These reforms resulted in improvements for some poorer members of society but led to increased stigmatisation and continued inequality for the 'undeserving poor,' e.g. abandoned families and unmarried single mothers, while the curtailment of 'outdoor relief' caused hardship to individuals traditionally regarded as 'deserving poor' e.g. old people and members of widowed families, (Thane, 1988). Despite these changes, large scale poverty still existed in the early 20th century as illustrated by the finding that one quarter of the inhabitants of London were still living in poverty (Humphreys, 1997).

The Liberal government of the early twentieth century laid the foundations of current day social services: the 1905 Unemployed Workman Act created labour exchanges; the 1906 Education Act provided free school meals; non-contributory age pensions came into being in 1908; and the first National Insurance Act was introduced in 1911. The first world war and poor economic performance affected economic resources in the following decades and limited state provision to small benefits, which included means-tested 'out-of work donations', the first major financing of council housing, the introduction of contributory pensions for widows, orphans and old people, and transitional payments for the unemployed (Spicker, 2006).

Work led by William Beveridge during and immediately after the Second World War, contributed to the establishment of what was widely termed a 'Welfare State'- a system built around a central ideal of universal employment, free care and free health provision (Glennester, 2000). During this era, legislation introduced free secondary education for all, the family allowance, the National Insurance programme, and the National Health Service, (Spicker, 2006). A third Rowntree survey conducted in 1951 concluded that reforms had worked, a declaration which coloured political and public opinion for the next 15 years. The 1960's saw renewed interest in child poverty, a concern generated by accumulated evidence of continual poverty for many in the UK. Evidence included work done by Able-Smith and Townsend (1964) who reported the number of families living in poverty had risen to an unexpected, unacknowledged level. This contributed to the formation of the Child Protection Action group (CPAG) whose lobbying of both the public and government contributed to increases in the Family allowance and the redirection of these payments directly to mothers (Green, 2005). Overall the post war reforms appear to have had a positive ripple effect on equality and improved living standards until the seventies.

b. The rise of inequality and child poverty, 1970's – 1997.

> *'The 'Welfare State' was not intended to respond to poverty; that was what the Poor Law had done. The main purpose was to encourage the provision of social services on the same basis as the public services – roads, libraries and so forth – an institutional model of welfare. Criticisms of the Welfare State in later years, however, were to concentrate increasingly on the problem of poverty,'*
>
> *Spicker, 2006.*

By the mid seventies average take home pay was falling for the first time in the post-war era. The seventies became a time of social unrest and growing general dissatisfaction. In 1979 the election of a Conservative government saw the emergence of a market led economy, under which the financial hole created by tax cuts was filled by indirect taxation and increased National Insurance contributions. This deepened inequalities as it impacted most heavily on poorer paid employees and benefit dependents (Le Grand, 1982), a section of society whose situation was deepened by pay restraints, redundancies and the phasing out of subsidies and monopolies (Glennester, 2000). The effects of these policies were shown by sharp rises of unemployment and poverty levels during the 80's and 90's, limitation of services and benefits, and growing levels of child poverty (see p.33). In 1997, after nearly 20 years of Conservative power, a 'New Labour' government came into power, a party which appeared to embody different ideologies and beliefs.

c. Post 1997.

> *'The Labour government that took office in 1997 inherited levels of poverty and inequality unprecedented in post war history. More than one in four UK children lived in relative poverty.....income inequality had widened sharply.'* *Stewart & Hill 2005, p.1.*

New Labour's willingness to recognise and address poverty was seen in their adoption of an official definition of poverty based on the number of households living on incomes less than half the national average. This was in contrast to previous governments who had refused to sign up to definitions of poverty agreed by the European Commission (Milbourne, 2004). A Comprehensive Spending Review (CSR) was set up to report on ongoing public spending levels and to inform on the spending reforms needed to meet the party's priorities, which included the addressing of social and economic disadvantage. Factors affecting people's lives were itemised as lack of income, lack of access to good housing, good education, good health and having a good local environment, in practice this meant addressing problems such as child poverty, unemployment, area deprivation

and educational and health inequalities (Stewart & Hill, 2005). Areas of disadvantage were recognised, e.g. three thousand neighbourhoods with problems of poverty, poor health and high levels of crime were identified in a report by the government's Social Exclusion unit. The report 'Bringing Britain together (1998) stated:

> *'The 44 most deprived districts had nearly two thirds more unemployment than average, one and a half times lone parents, mortality ratios 30% higher, a quarter more adults with poor literacy and numeracy, and two to three times the levels of poor housing, vandalism and dereliction.'*
>
> *Lupton and Power 2005, p.119.*

The government's response to the CSR included policies with the shared aim of meeting the needs of disadvantaged members of society. Some policies were formed with the intent of decreasing income inequalities whilst others concentrated on improving public services for all. Examples of this can be found in the increasing allowances given to non-working families with children under 11 who were claiming income support (Stewart & Hill, 2005), working families credit and 'child care tax credits' (later combined into the Child Care Tax), benefits which increased financial support for families with low income (Glass, 1999)

These examples illustrate the government's apparent early commitment to tackling poverty and social exclusion, their focus on children and families, and their goal of increasing equality of opportunity for many in society. Government sources now claim positive impacts have been achieved e.g. in reducing child poverty, a claim supported by Hills and Stewart (2005) who recognise that child poverty fell from 34% to 28% between 1996/7 and 2002/3 (after housing costs), but who also comment that poverty incidence has risen slightly for families with two non-working parents, and that child poverty was initially so high there is still some way to go to reach the EU average. Some feel the government has lost its original focus and could show renewed commitment to reducing child poverty and reducing inequalities by reorganising child payments (Wilby, 2007). UNICEF supports the idea that child poverty in the UK needs further attention as a 2007 report -'Child poverty in perspective: An overview of child well-being in rich countries'- raised further questions about the government's claim. Their study used different indices to measure the well being of people. Previous UNICEF research had used income poverty as a proxy measure for overall child well-being, but this recent study - which gained data from 21 developed countries - used six different dimensions: material well-being, health and safety, education, peer and family relationships, behaviours and risks, and young

people's own subjective sense of well-being. The UNICEF results show that the United Kingdom and the United States are in the bottom third of the rankings for five of the six dimensions reviewed, and the UK is at the bottom of the league for child well being. Government response included pointing out that the UK statistics used were out of date and therefore no longer representative, but accepted that more needed to be done to eradicate poverty.

A major concern of the new Labour government was that previous governments had failed to adequately address public services related to the development and progress of children.

> *'It was agreed by ministers that there should be a review of services for young children, reflecting a view that current provision of services appeared, in many cases, to be failing those in greatest need, and that there was evidence from programmes like Head Start and the Perry Pre-School programme in the United states, as well as experimental programmes in this country that comprehensive early years programmes could make a difference to children's lives.'*
>
> *Glass 1999, p.259*

This statement encompasses recognition of the need for better services to help young children in the UK, and refers the ability of early intervention programmes to meet this need. Consideration now turns to pre-existing child intervention programmes, the efficacy of which contributed to the formation and planning of a new national UK child intervention programme.

3.3. Early Child Intervention Programmes.

> *'Early intervention is a term that refers to a broad array of activities designed to enhance a young child's development. Ideally, early intervention starts with a comprehensive assessment of a child's and the family's strengths and needs and extends through the provision of appropriate supports and services to active monitoring and re-evaluation as the child develops.'*
>
> *Ramey & Ramey, 1998, p.110*

In practice, early child intervention refers to programmes such as child care or home visiting designed for children from birth until the time they enter school (Waldfogel, 1999). Much evidence of the efficacy of interventional programmes has come from research carried out in the United States (USA).

a. American Child Development Programmes

In America concern about the effects of poverty on individuals and society led to a 'war on poverty' in the 1960's and the introduction of interventional programs focused on improving the developmental outcomes of children. Since then, interventional child programmes have been designed and implemented for children in the USA, particularly for children considered to be at biological or environmental developmental risk, (Fuligni & Brooks-Gunn, 2003)

Child intervention programmes have varied i.e. projects have been implemented at regional and national levels, and constituent services have differed in:

> *'The location of the service (home based or parenting group), the target (the child, the mother, the dyad, the family or a combination), the timing (beginning prenatally, in infancy, in preschool), the intensity (full day programs to weekly home visits), the extensivity (1-5 years of intervention) as well as the curriculum (skills education, parent child interaction training, literacy skills, parental coping skills).*
>
> *Brooks- Gunn, 2003, p.3*

Evaluations of different programmes and services in the USA have contributed to present knowledge about the effectiveness of intervention services, these included:

1. The Perry Preschool project suggested programme intensity is important. The project, - a randomised control trial with 64 children in the intervention group and 64 forming a control group - was carried out between 1962-7 and targeted the intellectual and social development of children at risk of school failure. Programme children, (aged 3-4 years, at risk of developmental delay), received intensive preschool education for a period of 2 years. Teachers also visited the families homes for an hour and a half weekly, and parents attended monthly meetings with other parents facilitated by programme staff. Longitudinal data – collected until the participant children were 27 years old has associated the project with higher rates of pro-social behaviour, better academic achievements, higher rates of employment, income and family stability and lower rates of adult arrests and drug related offences. The study has been described as a landmark study which has demonstrated the benefits of early intervention and high programme intensity, a claim supported by the finding that many non-intensive programmes fail to be effective (Ramey & Ramey, 1998).

2. The timing of the intervention: Centre based programmes enrolling children during infancy, (e.g. the Abercedarian Programme, the Infant Health and Development Programme) had greater positive effects on children's cognitive and social development, than those which enrolled children later (Ramey & Ramey, 1998; Fuligni *et al.* 2003), this finding is however somewhat confounded by the fact that many early intervention programmes were also intensive (Ramey & Ramey, 1998).

3. The maintenance of effects: There appears to be a fade out of intervention effects over time. This finding has been challenged by some longitudinal studies of centre based programmes, (see below).

These findings cited in Brooks-Gunn (2003) were from studies that were relatively small, locally based programmes, a situation which while demonstrating important positive effects raises questions about the generisability and external validity of such findings. In the 1960's, USA congressional legislation established a wider interventional programme named Head Start, which was hoped would have similar positive effects on the development of disadvantaged children.

Head Start is a major early intervention programme which has existed since 1965 and now works throughout the American states, Columbia, Puerto Rico and the US Territories, and has reached over 21 million children. Services include preschool education, medical, dental, and mental health care, nutrition services, and efforts to help parents foster their child's development, (Love *et al.* 2005). Since Head Start's inception there has been controversy over whether or not the programme meets its aims, i.e. to improve the developmental and health status of poor children and allows them to begin school on the same basis as more advantaged peers, and whether it produces lasting benefits,

> *Policy makers and the general public appear to believe that the benefits of Head Start are well known and well documented. However a careful reading of the literature reveals that credible studies that demonstrate lasting effects of Head Start are limited. The studies that do exist are typically restricted to small geographical areas and specific racial groups*
>
> *Currie and Thomas, 1995, p.345*

In their review of interventional programmes Barnett and Hustedt (2005), contend that the debate about the benefits of Head Start has been complicated by methodological research flaws such as attrition, non-comparative control groups, non-representative samples, and the limitations posed by research studies which only assessed IQ changes. Despite these limitations, Barnett & Hustedt state the results indicate that:

- Short term studies including both smaller programmes and Head Start have generally shown that programmes for children at risk result in increases of 0.5 standard deviations in IQ and achievement.

- Some reviewers have reported that the positive impacts of Head Start and other programs for disadvantaged children decrease and fade over time, but more recent meta-analyses of longitudinal research suggest that while effects do diminish over time some persistent effects exist.

- Reviews of long term studies of education programmes, including Head Start, show impact to be mixed. Initial increases in IQ scores have been found to fade over time, but decreases in special education referrals and numbers of children being kept back a year at school are found in most large scale programs including Head Start.

Barnett and Hudstedt (2005) offer an alternative - or contributory - explanation of the debate around the effectiveness of Head Start, one related to programme resources and structure. They argue that the fact that Head Start lacks sufficient funding to produce the levels of intensity and quality of intervention achieved in better funded model programs, contributes to results which indicate that they are less effective. Although public opinion appears to view Head Start as a successful programme regardless of this possible financial limitation, the need for further research is being met by an ongoing longitudinal study of the programme which promises to add to current knowledge of its efficacy. However, additional findings are available from research conducted for Early Head Start (EHS) an American programme aimed at very young children.

EHS is a two generation programme formed with the intention of meeting the needs of low income pregnant women, and low income families with infants and toddlers. By 2002 the programme served 55,000 pregnant women as well as families with a child under three. EHS programme was formed after advisory committees in the early 1990's

identified the characteristics of successful infant and toddler programmes i.e: early antenatal services for pregnant mothers; use of a two generational approach; family centred services using social services and parent education to address self sufficiency; high quality child development services; continuous service provision with enduring support and smooth transitions to other services; caregiver continuity; appropriate intensity of service; integration of services (Berlin *et al.* 2003). A proportion of Head Start funding was redirected to EHS, and the programme began in 1995 with the aims of:

- enhancing children's physical, emotional, social and cognitive development
- helping parents promote children's development by fostering parenting competence, and by helping them with personal goals including economic independence
- providing individualised services
- developing supportive nurturing plans with parents,
- recognising the childcare needs of working parents,
- linking families to other community services,
- involving parents in policy and decision making in all levels of the programme.

Dickstein *et al*, 2002, p.232

Services and agencies for separate 'local' EHS projects are selected by local EHS programmes to best meet the needs of the local community. This involves selection from: home based services – provided through weekly visits and at least two group socialisations per month; centre-based services – provided through centre based child care and education, parent education, and at least two home visits a year; or a mixed approach in which programmes can provide home based, centre based or a mixture of both to different families, (Love *et al.* 2002). The EHS Research and Evaluation Project has focused on 17 sites from the first band of EHS programmes, with selection ensuring sites were roughly evenly divided between these three programme approaches.

Findings (Love *et al.* 2002; 2005) demonstrate different outcomes based on the programme type and the subgroups of participants receiving services:

1. Centre-based services enhanced participant children's cognitive development at 24 and at 36 months old. By 36 months service use was associated with reduced negative

aspects of children's socio-emotional development. Centre-based services also showed favourable impact on parenting outcomes, but not on self sufficiency activities.

2. Home based programmes showed positive impacts on child language development at age 24 months but not at 36 months. Positive effects on engagement of parents in play interactions when the children were 36 months old were also found. When fully implemented, the home based programme had stronger impacts on cognitive and language development.
3. The mixed approach was consistently associated with positive effects on language development and socio-emotional development. When fully implemented from an early stage, effect sizes were from 20 -50%.
4. Impacts on parenting at 24 months were associated with impacts on children at age 36 months.
5. The impact on outcomes of children whose mothers enrolled when pregnant was greater. These mothers also showed higher levels of some parenting measures e.g. supportiveness during play.
6. EHS increased the rates of participation in education of parents of first born infants, and reduced the number of families who had another child within 2 years of initial enrolment.
7. Effect sizes were larger in African American families.
8. EHS had strong impact on families with three of the five demographic risks counted. Low and High risk families showed less impact.
9. EHS benefited families where parents were at risk of depression: later depression rates were significantly lower than found in a control group.
10. EHS programmes increased school attendance in teenage parents, and enhanced their children's development.

The early intervention programmes implemented in America in the last four decades have tried to reduce the generational spread of poverty by improving children's learning experiences and providing comprehensive support. Many programmes have concentrated on environmentally at-risk children and provided compensatory experiences before children begin school (Fuligni & Brooks-Gunn, 2003). However financial resources and methodological limitations have effected the validity of some evaluative findings e.g:

'....primary limitations have to do with the generalizability of the samples. Many studies, although employing large samples and collecting rich data, are not nationally representative; or focus on a single city; or are representative only of children from certain populations.... ...additional limitations have to do with methods of assessing the impacts of the programmes.'

Fuligni and Brooks-Gunn, 2003, p.366

Interventional principles have been drawn up by Ramey & Ramey (1998) from their history and review of early interventions:

- Developmental timing – interventions which begin earlier and continue longer, afford greater benefits.

- Programme intensity – programmes that are more intensive, as measured by items such as number of home visits /week, number of hours/day, days/week and weeks /year produce larger effects. Children and parents who participate the most actively and regularly show greatest developmental progress.

- Direct v intermediary provision of learning – children in programmes providing direct educational experiences show larger, more enduring benefits than those whose programmes rely on indirect routes such as parent training.

- Programme breadth and flexibility – Interventions providing more comprehensive services through multiple routes to support children's development usually have larger effect than interventions with a narrower focus.

- Individual differences in programme benefits – Some children show greater benefits than others, e.g. children with LBW did better than those with VLBW, children whose mothers were most intellectually limited showed greater benefits.

- Ecological domination and environmental maintenance of development – Over time, initial positive interventional effects are likely to be lost as later experience is not of sufficient quality to retain, improve and maintain the improved developmental trajectory. (adapted from Ramey & Ramey 1998, p.115-117).

Brooks–Gunn, in a 2003 paper entitled 'Do you believe in magic?' adds further information by specifying the type of programmes or services which have proved more effective. Brooks-Gunn claims consensus exists between developmental and policy

experts that: early intervention programs have the potential to alter poor children's achievement in early school; almost all of the programmes with positive results on child outcomes have included centre based early interventions; with few exceptions (which appear to be related to the intensity and curriculum of services) home visiting programmes do not have much impact on child achievement; programmes which offer case management have reported poor results; whether combinations of approaches are most effective is not yet known, (NB. EHS findings appear to challenge this); effect sizes seen in early years lessen over the school years; effect sizes are largest for children who would have been solely cared for by family members without interventions.

Attention now turns to UK early intervention programmes, particularly to Sure Start a project formed with similar aims to Head Start and Early Head Start.

b. Early UK Interventional policies and programmes.

Historically, early child interventional practices in the UK have been based on local initiative programmes (Carpenter & Egerton, 2005), a practice which inevitably limited services and led to service rationing on risk and child protection issues (France & Utting 2005, cited by Garbers *et al.* 2006). This was despite evidence - such as that cited above - which consistently pointed to the advantages of providing services which promoted the developmental progress of disadvantaged children (Garbers *et al.* 2006). One exception can be found governmental action taken in 1968 to address the needs of disadvantaged young children in the form of the Educational Priority Area Programme (EPA). The EPA had similar elements to Head Start, in that it was provided services to promote the education, health and nutrition of disadvantaged children (Select Committee on Work and Pensions, 2003). This initiative appeared to have a beneficial impact on child development and highlighted the important link between children's educational attainments and the deprivation of the area the child grew up in. These findings contributed to a 1976-7 White Paper (Cmnd. 6845, 1976-7) which recognised the importance of addressing economic and social problems (housing, environment, community facilities) particularly in deprived areas such as inner cities, and the articulated the need for further action to address educational, health, social services, housing and transport issues. A consultative document of this time (Cmnd. 6869 1976-7) commented that provision of nursery education had expanded in recent years, and

described it as an area of growing interest especially in relation to the needs of children with backgrounds of disadvantage. Further Parliamentary commands of this time refer to

- the importance of parental involvement, and of home and community influences in children's education (Cmnd 4566, 1970-1)
- the developmental significance of children's early intellectual, social and emotional needs and experiences; the importance of the standards of day care for under fives (Cmnd 5629, 1974)
- The need to provide services which promote confidence in parents. To promote this it was recommended parents should well be informed and involved in their child's development and health (Cmnd 6684, 1976-7).

Such evidence suggests the issue of early development and education, particularly that of children living in deprivation, continued to be of governmental interest for a large part of the 1970's. However a search for later references related to early child development in 'Portcullis' (the parliamentary database) revealed that although the period 1970 -1997 resulted in 416 'hits', 385 of these were for documents produced between 1970 and 1979. This suggests a period of decreased interest, recognition, consultation or action in relation to the development of young children existed between 1979 and 1997, and invites criticism of the governments of this time who it seems, chose to ignore the effects of deprivation on children in the UK despite evidence from USA early intervention programmes and positive findings within the UK. In the nineties, a Helios 11 study of European Union countries reported that the UK was the only nation without a policy in relation to Early Child Intervention (Sohns, 2004, cited by Carpenter & Egerton, 2005).

The need for a national strategy to target social exclusion and promote the development of children was recognised by the 1998 Cross-Departmental Review of Services for Young Children, which included acknowledgment that evidence based on US interventional programmes was some of the most comprehensive available (Select Committee on Work and Pensions, 2003). Since then the government's response has been strong, including: 'Every Child Matters' which addresses social exclusion and child development; 'Change for Children' a programme designed to reform and prioritise children's services; 'Together from the Start' which provides guidance for services for young disabled children; the National Service Framework for Children, which gives new national standards for children across national health, social and education services,

(Russell, 2005). The government's response included Sure Start a 'flagship programme' formed to address the problem of the non-optimal development of many children living with disadvantage,

> *Jack Straw, then Home Secretary, announced in Parliament the establishment of Sure Start with a funding package of £450 million over the first three years 1999-2002. The funding was earmarked to set up 250 Sure Start Local Programmes (SSLP's) in the areas with very high concentrations of children under four living in poverty. Each programme would have a defined area of around 'pram pushing distance' to new services being established. The average sized programme would reach around 700 children under four, with a basket of integrated health, education and social welfare services.*
>
> *Eisenstadt, 2007, p.viii.*

3.4. Sure Start: the national UK intervention programme.

Sure Start was planned as a centrally funded national programme which was expected to have had £1.8 billion invested in it by 2007-8 (Deven, 2006). Progressive universalism - the practice of providing support for all but more support for those who need it most - was, and is, at the heart of the vision for Sure Start (Balls, 2006). In practice, the programme was made up of area based community initiatives, consisting of multiple local agencies placed in recognised areas of deprivation, providing integrated services that were directed by local levels of need. Local agencies varied: in services; in programme structure; in funding sources. This situation was partially caused by different responses to local contexts, needs and priorities, but also because the responsibility of the services for the under-fives in the UK lay with devolved administrations, which led to regional differences in the policies of Scottish, English and Welsh governing bodies, differences which affect resident children and young people, (Wincott, 2004; Stewart & Hill, 2005).

The next section will describe the aims and objectives of Sure Start, review the findings of English local and national Sure Start evaluations, and then turn to social policies in Wales, Sure Start in Wales, the setting of Rhondda Cynon Taff and the work of the Rhondda Cynon Taff Local Sure Start Agency.

a. The aims and objectives of Sure Start

The Theory of Change lay behind the Sure Start approach. In relation to the Sure Start programme this theory proposes that changes which improved existing services for families would positively impact on the functioning of children, families and

communities (Ball *et al.* 2006). More specifically, Sure Start targeted child development through a two generational approach in which interventions sought to increase parenting knowledge and parenting skills, thereby adding to and enhancing earlier interventional practices in the UK, practices which previously had focused more directly on promoting child development in educational settings (Oliver & Smith, 2000).

Sure Start was designed as an evidence-based programme, i.e. designed using existing knowledge of the types and characteristics of interventions that have demonstrated effectiveness (Oliver & Smith, 2000),

> *'Sure Start is a radical cross-departmental strategy to raise the physical, social, emotional and intellectual status of young children through improved services. It is targeted at children under four and their families in areas of need. It is part of the Government's policy to prevent social exclusion and aims to improve the life chances of younger children through better access to early education and play, health services for children and parents, family support and advice on nurturing. It will be locally led and locally delivered but will be based on evidence from the United Kingdom and elsewhere on 'what works' in terms of improving the life chances of children and their parents.'* *Glass, 1999, p.257*

Consultation of the Sure Start and the National Evaluation of Sure Start websites (surestart.gov.uk, ness.bbk.ac.uk) reveals the aims and principles of Sure Start.

The stated aims of the programme:

- To promote the physical, intellectual, social and emotional development of children especially those living with disadvantage;
- To improve children's ability to learn and be ready for school;
- To strengthen families and communities;
- To improve the productivity of operations in the area.

While the programme's principles dictated services should be:

- Two generational: work with parents and child,
- Non-stigmatising, culturally appropriate, and sensitive to the needs of children and parents.
- Available for all
- Multifaceted and flexible at the point of delivery: able to address the multiple factors causing difficulties in communities and families

- Long term services which start early.
- Locally driven i.e. involving parents and communities, and professionally coordinated
- Outcome driven

In its initial, early years Sure Start in England mainly operated through Sure Start local programmes (SSLPs) in identified deprived neighbourhoods where low income, unemployment and child poverty are more than double the national average (Barnes *et al.* 2003) and whose communities included 400 -800 children aged from birth to four years of age. The Sure Start Unit - a cross-departmental administrative group – prepared guidance for local programmes which contained key Sure Start principles;

> *'Emergent SSLPs were told that services must coordinate, streamline and add value to the existent services in the SSLP area, including signposting to existing services; involve parents; avoid stigma; ensure lasting support by linking effectively with service for older children; be culturally appropriate and sensitive to particular needs; be designed to achieve specific objectives relating to Sure Start overall objectives and promote accessibility for all local families,'*
>
> *Melhuish & Hall, 2007, p.13.*

It can be argued that SSLPs differed from many other early years intervention programmes e.g. the Abecedarian project, Early Head Start, by being area based, universally available to all resident children under four and their families, and because SSLPs were not directed by a programme with prescribed curricula or set of services. Allowing for this, although local areas were allowed much flexibility in their programme planning, they were all required to provide five core services: outreach and home visiting; support for families; good quality play learning and childcare; primary and community health care; support for families with specialised needs (Ball *et al.* 2006; Melhuish & Hall, 2007). At the start of Sure Start many SSLPs in England worked from Sure Start-funded centres, thus providing a 'hub' for their services, management and staffing structures, therefore offering accessible, integrated services for young children and their families in a context where professionals from different services can work together (Barnett, 2005). In England SSLPs were directly funded by the Department for Skills and Education until 2006. At this time funding and responsibility was transferred to Local Authorities, and children's services - including Sure Start, Early Excellence Centre and Neighbourhood Nurseries – have been provided via Children's Centres. The Centres use

a model of service provision which ensures the provision of: integrated early learning and childcare; child and family health services; support and outreach; support for childminders; and help for children and parents with special needs, together with links with Jobsure Plus.

Amongst the principles of Sure Start is an obligation for services to be outcome driven. This demanded the evaluation of services and programmes to increase understanding of the process, impact and outcomes of local programmes, to discover how well services are meeting local need, and to allow subsequent services to be enhanced and improved on the basis of evaluation based evidence. In England, national and local evaluations have/are being carried out for Sure Start, with information about the findings published on the National Evaluation of Sure Start (NESS) website.

b. Local Sure Start evaluations.

Guidance for local evaluations available on the NESS website recommends that evaluations should be guided by a set of core common questions:

1. Are the services we provide making a positive difference to service-users?
2. If yes, then what are the impacts of these services and how were they achieved?
3. Are we reaching all the people who want or need our services, who aren't we reaching and why?
4. Are we employing the best processes to deliver our services?
5. Are we delivering the best range and mix of services?
6. Are the services cost-effective and do they provide the best value for the money?

Harrington *et al.* 2005, p.16

Much evidence - from the NESS and local reports of SSLP's - is available in publications and on the agency and evaluation websites, sources which provide important information about service challenges and achievements and can thus be used to guide improvements to service provision. Many reports suggest services have made positive differences which were valued by service users (e.g. Barry, 2002; McKinnon *et al.* 2003; Venus, 2004), with service use facilitated by: easy access to and good signposting of services (Malik, 2005); the friendliness of staff (Simpson, 2002; Luckock *et al.* 2002; Yates & Clarke, 2002): good information about services (Sharp, 2002; Johnson *et al.* 2004): and service providers who actively targeted and visited 'hard to reach' families

(Sharp, 2002). Evaluations discovered that many families in SSLP areas felt local child and family services had improved (e.g. Sharp, 2002; Barrow *et al.* 2003; Johnson 2004).

In contrast to these positive findings, evaluations found evidence of barriers to service use. These included: lack of awareness of Sure Start services (e.g. Luckock, 2002; Johnson *et al.* 2004), lack of information about services (Simpson, 2002; Barrow *et al.* 2003; Howarth & Foreman, 2006) lack of service provision for working parents (Barrow *et al.* 2003; Sahota 2005), parental shyness or lack of confidence (Sharp, 2002), feelings that services should respond to actual need, not to governmentally perceived need (Johnson, 2004), transport problems (Luckock *et a*l. 2002; Simpson, 2002; Killingbeck, 2003), difficulties in engaging fathers in service use (Sahota, 2005), the stigma of accessing support (Luckock *et al.* 2002; Simpson, 2002; Johnson, 2004), and financial problems (Simpson, 2002). Some evaluations found that families are isolated from services or 'hard to reach' (Simpson, 2002) whilst others found 'hard to reach' families will use services but it may take time and intensive input to engage parents (Weinberger, 2003; Howarth & Foreman, 2006). Another strand of evaluation investigated the reality of working in multi-agency programmes and found interagency working was facilitated by common professional language but hindered by lack of understanding of other workers roles and responsibilities, and by insufficient time or enough physical space to allow adequate interagency communication (Luckock *et al.* 2002; Dahl et al, 2005). One final area of interest was the cost-effectiveness of SSLPs, but an NESS synthesis of local evaluations concluded that cost effectiveness was difficult to evaluate at that time as methods employed by different evaluators precluded comparative analysis while lack of appropriate expertise within local agencies to evaluate this area has also been a problem (Ellison *et al.* 2006).

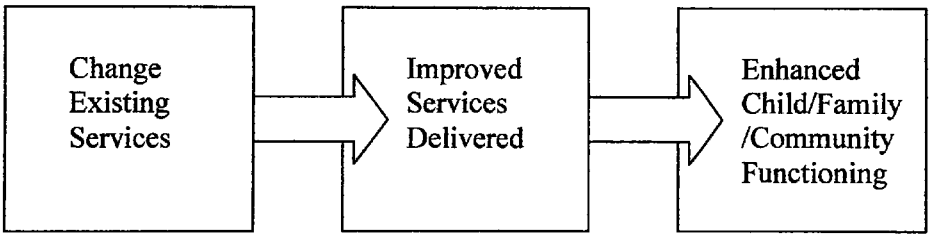
The above evidence showed that SSLP evaluations served many useful purposes by;
a) Highlighting positive services and/or aspects of services that were utilised and valued,
b) Showing barriers that prevented or discouraged parents from utilising services,
c) Demonstrating the limitations of programmes and service provision,
d) Providing lessons for policy makers, evaluators and programme planners, as displayed by the problem of cost effectiveness evaluations and in the opinions of service users.
However as yet the literature cited has not addressed the important question of whether SSLP's were having an effect on the development of young children in their local area.

Many local studies included evidence of impact and outcome on - parenting skills, (e.g. Yates & Clarke, 2002 Weinberger 2003); parenting emotional or social support (e.g. Weinberger, 2003; Saidana & Bywaters, 2006); employment and voluntary work (Killingbeck, 2004); parent:child interaction (Taragon, 2004; Saidana & Bywaters, 2006) and on children's development e.g. socialisation (Yates & Clarke, 2002; Sahota, 2005) and learning opportunities, (Saidana & Bywaters, 2006). However, it can be argued that the use of evidence from individual SSLP evaluations - evaluations which often involved small numbers of service users and were looking at different areas of service provision or using different methods to monitor and assess similar projects - made it difficult to generalise local findings to all Sure Start areas. To address this, the National Evaluation of Sure Start (NESS) is conducting a major study concerned with the impact of Sure Start local programmes on the development of children, families and communities.

c. The National Evaluation of Sure Start.

Sure Start is guided by a model based on the theory of change (Figure 3):

Figure 3: The Sure Start model.



from which emerge three core questions needing evaluation:

1. Do existing services change?
2. Are delivered services improved?
3. Do children and families benefit

NESS Methodology report, p.1

The NESS is addressing these questions in five different modules: implementation evaluation, impact evaluation, local community context analysis, cost-benefit analysis and support for local evaluations.

The NESS impact module is investigating the effect of Sure Start Local Programmes on the functioning of children and families in their local programme areas. In the *'Impact of*

Sure Start Local Programmes on Children and Families' Belsky and Melhuish (2007) report early evaluative results that showed few statistically significant impacts were identified in the early years:

- Family function: Mothers/primary carers of 3 years olds in Sure Start areas treated their children in a significantly more accepting warmer way; the non-teen mothers of 36 month olds in Sure Start areas showed less negative parenting than mothers in comparison area; significantly lower levels of household disorganisation was found in the households of Sure Start 9 month olds
- Effects on children: 36 month old children of non-teen mothers in Sure start area showed fewer behaviour problems and better social competence than those in comparison communities, but the children of teen mothers in Sure Start areas scored lower on social competence and verbal ability and higher on behavioural problems than peers in comparison communities
- Community effects: Despite the 'theory of change' underlying SSLP's, which predicted that positive changes to services and communities should result in improved functioning of families and children, the mothers of 9 and 36 month olds in Sure Start areas reported no change in use of services when compared to control group mothers. In addition the mothers of 36 month olds in Sure Start areas rated their communities less favourably when compared to control mothers.
- Living in a SSLP area appeared more effective for children from relatively less deprived backgrounds, while children from more deprived households appeared to have been adversely affected by living in a SSLP area

These findings caused early speculation that parents with better personal, social and economic resources appeared better able to take advantage of SSLP services (Belsky & Melhiush, 2007). Caution about expecting definitive results later was also expressed by Rutter who warned evaluation was:

> *'least likely to provide definitive answers. The reason is that each SSLP is unique in what it does, and there is no straightforward way in which the entire complexity of the variation among programmes can be used to provide clear cut quantitative answers on what works. Of course, important clues will come from the case studies still to be undertaken, but the end product will be helpful suggestions, rather than answers.'*
>
> *Rutter 2005, p.138*

This apparent pessimism about the likelihood of obtaining positive findings from Sure Start evaluations proved premature. A recently published report based on a exploration of variations in the effectiveness of Sure Start Local Programmes (Anning *et al.* 2007) contained the following key findings about aspects of service provision which were most proficient, and which could be consulted for guidelines to increase effectiveness in SSLPs nationwide:

- Effective and proficient SSLPs were those which took a holistic approach (in vision, empowerment, communication, and ethos) to implementing the Sure Start vision
- Effective SSLP's were those which built on the strengths of inherited service provision and were creative in improving and setting up services
- Productive strategies were identified as: employing systemic, sustainable structures in governance and management/leadership; having a welcoming, informal but professional ethos; using practices which empowered parents, children and practitioners
- At operational level good practice included: auditing and responding to community priorities in universal services; early identification and targeting of children and parents who would benefit from specialist services; recruiting, training and deploying providers with appropriate qualifications and personal attributes; managing the complexities of multi-agency teamwork
- Overall reach figures were disappointing. Those who used services often used several and reported satisfaction with them. But services offered at traditional times and in conventional formats did not reach many fathers, black and minority ethnic families and working parents
- Barriers to attracting 'hard to reach' families were difficult to overcome
- Few programmes demonstrated proficiency in (1) systematically monitoring, analysing and responding to patterns of service use (2) or rigour in measuring the impact of treatments
- Multi-agency teamwork, including effective ways of sharing information, and clarity about the cost effectiveness of deploying specialist and generalist workers strategically, proved difficult to manage and operate

The recent report (NESS, 2008) provided the most positive results to date. The second phase of their impact study drew on findings from 9000 three year old children and their families, who had been involved in the first phase when the children were nine months old. Comparisons of these children with a control group drawn from similar areas not living in a SSLP area showed that Sure Start area children demonstrated:

- Better social development
- More positive social behaviour
- Greater independence/self regulation

While families in Sure Start areas demonstrated:

- Less negative parenting
- A better learning environment
- Use of more of child and family development services than control group families.

An additional positive finding was found in the health of SSLP area children. When compared to controls a higher percentage of 'Sure Start' children had received recommended immunisations and a lower number of accidental injuries in the year before the data were collected. When looking at the results of subgroups they seem generalisable across the groups, i.e. more disadvantaged groups such as families with teen mothers and unemployed households also benefited.

Although these findings are encouraging, the NESS research team draw attention to the limitations of the control group used. The comparison group was drawn from the Millennium Cohort Study (MCS) and despite care taken during area selection and data analysis to minimise differences, little could be done about the two year difference between the time of data collection for SSLP three year olds, and the three year old MCS children. This time lapse may have impacted on health outcomes, especially - as mentioned in the report - on the immunisation rates as national child vaccination rates have increased in recent years. With this limitation acknowledged, credence must be given to conclusions drawn in the 2008 report which point out that a greater impact may well be felt as children and families involved in this second stage of evaluation have been exposed to SSLP areas for longer periods of time; a time during which SSLPs were more

likely to become more effective as it took at least three years of operation for SSLPs to become functional (Meadows, 2006 cited by NESS 2008). The authors also point out that SSLPs have become children's centres with more clearly focused services, and increased awareness of the difficulty of reaching the most needy families. When this evidence is added to that supplied by evaluations such as EHS, it strongly suggests that increased exposure to more effective Sure Start services is having/will have beneficial impacts on the development of some children in targeted areas of England. It also makes future NESS findings of great interest, although it is also of importance that no complacency is apparent within the latest report as they acknowledge

'Such improvements have a long way to go'

NESS, 2008, p.30

Attention now turns to Wales and to the subject of the present study; a SSLP situated in Rhondda Cynon Taff (RCT). The section will begin with a discussion of the context of Sure Start in Wales in relation to overall child policy and strategies, before focusing on the area of RCT and its Sure Start local programme.

3.5. Childcare and Early Years policy in Wales.

The devolved administrations in Scotland and Wales developed purposeful strategies for children in general, with the Welsh Assembly's 'Learning County' strategy profoundly affecting child care and early education in Wales. Welsh strategy led to a change in the focus of the entire curriculum which now considers life up until the age of seven as a distinct life stage or phase based on the concept of learning through play (Wincott, 2004). Guidance from the Welsh Assembly Government during this time of change led to much reorganisation of the services providing early years and childcare services in Wales, and impacted on Sure Start in Wales. Sure Start in Wales evolved alongside English Sure Start since the national instigation of the programme. In 2000, Welsh SSLPs received direct funding from the Welsh Assembly Government, although this did not create independent 'stand alone' local agencies, e.g. Rhondda Cynon Taff Sure Start initially operated under the Early Years Development and Childcare partnership. In 2003, after a review of existing funding and a period of consultation, Sure Start programmes in Wales lost their direct funding and Sure Start in Wales merged with the Children and Youth Partnership fund and the Child care strategy to form 'Cymorth', a children and youth support fund administered through children and young people's

partnerships within local authorities, (www.surestart.gov.uk). In 2006, the Welsh Assembly implemented a National Service Framework (NSF) for Children, Young People and Maternity Services in Wales. The NSF is guided by seven core aims, which work to ensure all children:

1. Have a flying start in life;
2. Have a comprehensive range of education and learning opportunities;
3. Enjoy the best possible health and freedom from abuse, victimisation and exploitation;
4. Have access to play, leisure, sporting and cultural activities;
5. Are listened to, treated with respect, and have their race and cultural identity recognised;
6. Have a safe home and a community which support physical and emotional well-being
7. Are not disadvantaged by poverty

The National Service Framework. Welsh National Assembly, 2006, p.1

The NSF sets the quality of services provided for children, young people and their families and provides a 'framework' within which the different agencies providing services and care for children can work together, although the delivery, co-ordination, auditing and monitoring of outcomes, which should take place at a local level (NSF, 2006). Reading through the NSF shows it shares - indeed arguably may have been built - on the principles and aims of Sure Start in relation to antenatal and early years care, but no mention of the Sure Start organisation can be found, although it is possible that referral to their services may be included and inferred, e.g.

> *'Although voluntary, and many independent, organisations have not been specifically identified as 'responsible organisations' within the key actions of the NSF. it is acknowledged that they have a vital role to play, through the Children and Young People's Framework partnerships in contributing to the delivery of the NSF. Where voluntary sector or independent sector services are commissioned it will be the responsibility of the commissioning body to ensure they deliver services to the standards required,' NSF, p.4*

Although the direct funding and arguably the relative autonomy of SSLP's in Wales have undergone recent changes, the programme and services of Sure Start in RCT appear

markedly unchanged at point of delivery. The discussion of RCT Sure Start will be preceded by a section describing Rhondda Cynon Taff.

a. Rhondda Cynon Taff (RCT).

RCT is located north of Wales' capital city, Cardiff. The county consists of populated towns set in undeveloped, often forestry lands. Historically, RCT was a major contributor to the coal industry and the effects of the collapse of the industry, together with the related pit closures has impacted heavily on the area. Articles in the media (e.g. Buchanon, 2005) cite research into the legacy of mine closures as showing the 'devastation' suffered by the Welsh mining communities, e.g. high levels of unemployment (somewhat disguised by high levels of local claimants of incapacity benefit) illustrated by lack of job opportunities, complicated by the fact many jobs are geographically beyond reach (Fothergill, 2001). Indeed the Local Wanless Action Plan for RCT comments that the county population of 232,000 has declined by 3,000 since the 1991 census, and attributed this to, among other factors, outward migration and a growing elderly population.

Key statistics from the 2001 census for RCT can be found in Table 2. For comparative reasons the table also shows overall 2201 figures for Wales, and for RCT in 1991 (Wales 1991 figures could not be found). The table suggests increasing levels of ill health and single parenthood, high levels of poor education, and continuing transport problems within the area.

Table 2: 2001 Census figures for RCT (ONS):

	Rhondda 2001	**Wales 2001**	**Rhondda 1991**
Total population	232,443		
Population age 16+	79.0 %	79.0 %	79.3 %
Aged 0 – 15	21.0 %	20.2 %	20.7 %
Aged 75 +	8.6 %	8.3 %	7.3 %
Ethnic origin			
Non-white group	0.7 %	2.1 %	0.6 %
Place of birth			
Wales	93.6 %	75.4 %	93.8 %
Other UK	5.4 %	21.4 %	5.2 %
Else where in UK	0.4 %	1.3 %	0.3 %
Non-EU	0.6 %	1.9 %	0.6 %
Marital Status (age 16+)			
Single (never married)	27.9 %	28.0 %	23.8%
Married	50.7 %	52.0 %	58.1 %
Separated or divorced	10.4 %	10.6 %	6.4 %
Widowed	10.9 %	9.4 %	11.7 %
Health			
Limiting longterm illness	31.1 %	23.3 %	26.2 %
General health not good	18.5 %	12.5 %	n/a
Providing 'unpaid care' 50+ hours/week	4.3.%	3.1 %	n/a
Households			
Total number	30,049		
Average household size	2.39	2.37	2.53
One person	28.9 %	29.1 %	25.8 %
Lone parent with one child	8.5 %	7.3 %	4.2 %
Pensioner household	27.0 %	25.6 %	27.8 %
House without central heating	8.4 %	7.5 %	23.9 %
House with at least one person with longterm illness	55.3 %	42.4 %	48.2 %
Tenure			
Owner occupied	76.1 %	71.3 %	78.0 %
Local Authority	8.3 %	13.7 %	14.2 %
Housing association/social Landlord	4.0 %	4.2 %	2.7 %
Private landlord	7.6 %	7.4 %	4.4 %
Other	4.0 %	3.3 %	0.8 %
Transport			
House without car/van	37.1 %	26.0 %	45.1 %
Education			
Adults without qualifications	47.2 %	33.0 %	n/a
Adults with degree or more	9.1 %	17.4 %	2.2 %

Source:2001 Census

James *et al.* (2006) make the following additional points in their overview of RCT:

- RCT is almost four times more densely populated than Wales as a whole
- Life expectancy at birth for people born in RCT is approximately one year less than in Wales overall
- A slightly smaller percentage of the working age population are economically inactive as compared to the rest of Wales
- The median average pay for full time workers in RCT is approximately £20.500, this is £900 below the national median wage
- The median price house price in RCT in 2005 (£80.000) was £40.000 less than in Wales as a whole
- The rate of road accidents is nearly double that in Wales overall
- The Welsh Index of Multiple Deprivation 2005 (WIMD) ranks electoral areas in terms of deprivation. An above average proportion of RCT's areas fall in the 10% most deprived areas in Wales, and the majority of RCT's areas are more deprived than the Welsh average

adapted from James *et al.* 2006, p.5

Further consultation of the WIMD shows that only nine of the fifty three electoral divisions within RCT are ranked above the middle position (twenty seven) of the table. A map of RCT, based on the WIMD (Appendix 1), shows the distribution of areas of relative deprivation and that severe deprivation is concentrated in the north of the county with deprivation decreasing as you move to the south. A table constructed from this map (Appendix 2) which places the electoral wards in the five levels of deprivation used in the map, and gives the number of wards in each category. The table shows how the majority of electoral wards are ranked as severely deprived. With statistics and literature confirming Rhonda Cynon Taff as an area of severe deprivation, it becomes an obvious choice for a Sure Start Local Programme.

b. Rhondda Cynon Taff Sure Start (RCTSS)

Sure Start has operated in Rhondda Cynon Taff since 2000 and provides multi-agency services for expectant mothers and families with children from birth to the age of four. In line with the programme recommendations, Rhondda Cynon Taff Sure Start has evolved and changed in the time since first implementation. Therefore the following information

about the programme is based on a review of all projects associated with Sure Start in Rhondda Cynon Taff in 2004 (Boot & Macdonald, 2004) as this corresponded with the start of the present study. Before itemising the services provided or funded by RCTSS, there is an important feature of the programme structure in Rhondda Cynon Taff that must be considered. As discussed earlier, in England SSLPs were mostly located in designated areas or neighbourhoods of deprivation and are now incorporated in children's centres. In Rhondda Cynon Taff deprivation exists in many areas throughout the county. In recognition of this, although service provision is concentrated in and more easily accessed in some areas - notably those with the few existing children's centres – most RCTSS projects are universally available to all families expecting or living with children aged four or under who live in RCT.

The core RCTSS staff consists of: health visitors, mental health counsellors, nursery nurses – termed child care workers, social support workers, breast feeding advisors, a speech and language team called ' Talkabout', a father's advisory and counselling service, and a Playbus which visits local communities. Although the core team appears to have been mainly drawn from health services, these services are supplemented by input from and links with diverse further local services.

The following brief review of Rhondda Cynon Taff Sure Start services is drawn from the Boot and Macdonald (2004) review, but presents the information differently i.e. categorised by the type of service provided. It is recognised some services could be placed in more than one category and ultimately categorisation is based on the interpretation of the reviewer. The description of services is followed by Table 3 which places individual services in one of the five core services required from all SSLPs.

a). Direct funding for individual services:

i. Assisted places scheme; a programme which enables children from families with poor income to gain up to three half-day sessions in a pre-school playgroup.

b). Children's centres:

Rhondda Cynon Taff Sure Start is primarily associated with two family or children's centres. These centre are mainly staffed by voluntary bodies, but RCTSS has a role in each. The centre's are cuurently called ' a family centre' and a 'playzone, this

terminology should not be confused with the 'Children's Centres' being currently formed across the UK (p.54), therefore these will be referred to as 'Family Centres

i. Glyncoch: a family centre within a particularly deprived area of Rhondda Cynon Taff (WMID 26/865, Rhondda Cynon Taff 4/53), which provides multiple services for parents and children. Glyncoch. is managed by Barnardo's, but funded by Sure Start.

ii. Penywaun: a NCH centre in the most deprived area of Rhondda Cynon Taff (WMID 2/865, Rhondda Cynon Taff 1/53) historically often supported by Sure Start 'slippage' funding. In April 2004 Sure Start began funding a part time leader for the registered playgroup thus supporting the centre's commitment to provide structured childcare to children in the community.

c). Services targeting young parents

i. Barnardo's 'Open Door': a project in a major town, which provides services for young people (aged 16 -21) who are expectant or actual parents, or have been in care, or assessed as in need. Sure Start funds a development worker to provide advice and support in parenting issues.

ii. Books and Babies: provides alternative education for expectant mothers and new mothers under the age of 16. Sure Start has aided the scheme with funding to improve premises, increase service provision, and provide good quality child care.

iii. Next Steps: offers learning opportunities to improve parenting skills, parent's interaction with their children and parent's self esteem and self confidence. Courses include parenting skills, arts and crafts and holistic studies. Quality child care is provided.

d) Children and family services:

i. Health:

Breast feeding advice; a service supports breast feeding mothers and promotes understanding of the practice through individual support by advisors, and training for professional and parent groups.

ii. Family Support:

Health Visitors: Three Sure Start Health Visitors whose work mainly involves interventions for child behaviour problems and positive parenting. Sure Start

childcare support workers: eight workers funded by Sure Start are attached to social service teams and work with families at home to improve parenting skills and promote improved interaction between parents and children. Sure Start childcare workers: Sure Start funds nine childcare workers who work in individual family and group situations to support and guide parents over a range of health and child development issues. Funding for RCT Home-Start, Home-Start is a national voluntary parental and family support organisation which provides one to one support for families experiencing problems or difficulties.

e) Education:

i. Parent and toddler group support: grants are available from Sure Start to support groups through the county to purchase new equipment, pay rent or fund staff wages during the establishment of a new group; Interlink is a voluntary organisation which aims to set up new playgroups in areas without any or sufficient groups, Sure Start funds a part-time worker to facilitate the organisation; Sure Start also fund a play-worker in a parent and toddler group and the associated play group as part of a community revival strategy.

ii. Wales Pre-school Playgroup Association training courses: Sure Start helps fund the cost of training courses offered by the Wales pre-School Playgroup Association. Courses aim at improving the number and quality of play and mother and toddler groups.

iii. Education for children with special needs:

Sure Start funds a) Law yn Llaw: an organisation who support the attendance of children with special need/disability at pre-school education. b) The Portage service: the service supports the needs of children with special requirements or a disability by working in the home environment to promote communication skills and improve or modify behaviours. Sure Start fund one portage worker.

iv. Toy Library: this service operates at seven different locations throughout Rhondda Cynon Taff. It is funded by Sure Start and loans age appropriate toys and books to families, with the aim of promoting children's development.

f) Parenting

i) P.A.C.T. is a Sure Start funded initiative, which aims to coordinate and develop parenting support within Rhondda Cynon Taff by providing opportunities for interested parents and workers to network and share information.

ii) Rhondda Fach parenting support group. It aims to promote good parenting, encourage participation and address isolation. Sure Start contributes by funding a childcare worker at the group.

iii) Talkabout: A Sure start team of a speech and language therapist,, a development worker and to childcare workers. The team holds workshops to help parents develop their communication with their children. and provide training for other professionals .

iv) Valleys Kids: The valleys kids project is based in a Rhondda Cynon Taff community. Sure Start contributes to the project by funding a play-worker who helps structure play activities for parents and their children aged 0 -3 years old.

G) Safety

i. Safe start: A scheme funded by Sure Start which helps families purchase safety equipment for the home and highlights safety issues.

Table 3: Relation of RCT services to the five core services.

Outreach & Home visits	**Support for families & parent**	**Good play, early learning, child care**	**Health care and advice**	**Support for special needs**
SSCCW SSHV SSCSW	SSHV SSCCW GLYNCOCH, PENYWAUN, OPEN DOORS, BOOKS AND BABIES, NEXT STEPS, DAD'S ADVISOR, HOMESTART, VALLEYS KIDS, P.A.C.T., COUNSELLOR	SSCCW GLYNCOCH PENYWAUN NEXT STEPS ASSISTED PLACES TALKABOUT TOY LIBRARY WPPA RRHONDDA FACH	SSHV GLYNCOCH BREAST FEEDING ADVISOR PE NYWUAN TALKABOUT SAFE START	PORTAGE HOMESTART LAW YN LLAW

b. i. Rhondda Cynon Taff Sure Start Evaluations.

The Rhondda Cynon Taff Sure Start Management committee is made up of members from; Education and Children's services; the Local Health Authority; statutory and voluntary sector organisations. It is the body which decides which services and/or programmes would benefit from formal evaluation, and commission the work from the University of Glamorgan. Previous evaluations have obtained information about the provision and uptake of some interventions, along with substantial useful feedback from service users (Glossop & Macdonald, 2002; Haywood & Macdonald, 2003). Commissioned work has also included an audit of Sure Start services in 2004 (Boot & Macdonald, 2004). In addition many Sure Start projects have parental evaluations built in to service delivery, and Rhondda Cynon Taff Sure Start produce an annual 'Report on Progress' to meet the directions of the Welsh Assembly Government.

Glossop & Macdonald (2002), evaluated the process and outcome of three Sure Start projects: Talkabout, the Sure Start Health Visitor and Child Care Worker' team, and the evolution of a new parent and child group in an area of severe deprivation. Hayward & Macdonald (2003) evaluated a creche at Penywaun family centre which is utilised by the children of parents attending courses at the centre and staffed through Sure Start funding, and Sure Steps - a playgroup setting for children with autism/communication difficulties.

Study findings include high parental satisfaction for all the projects evaluated. More specifically Glossop and Macdonald (2002) reported that:

- Parents felt the Talkabout service stimulated parent/child communication, developed parental play skills and impacted on the home environments. Most parents reported applying the knowledge from workshops to the home situation
- The Sure Start childcare workers observed improvements or benefits for the majority of participant families, and reported that three quarters of family difficulties (e.g. sleep, behavioural, toilet training) were resolved by the Sure Start health visitors
- The parent group study provided information about the progress and possible challenges when setting up new community groups, and showed that parents felt the group had benefited their children's social and language skills: Sure Steps

improved autistic children's communication, social and concentration skills, and gave parents systems and practices to use at home.

Details from the Boot & Macdonald (2004) audit have been used above (section 3.5.b), but the report also provides information about the methods Sure Start projects use to monitor and evaluate their work. Due to the merging of early years services and Sure Start under the 'umbrella' of Cymorth, Sure Start was involved in many projects throughout Rhondda Cynon Taff which use Cymorth Quarterly Monitoring forms, Cymorth Progress reports, as well as the Rhondda Cynon Taff Sure Start Progress report. Consultation of all three sources of information led to the conclusion:

> *'The audit shows that many of the projects did not provide full and detailed data on monitoring or evaluation; that many of the forms were incomplete.'*
> *Boot & Macdonald 2004, p.4*

Further concerns which have been identified by earlier Rhondda Cynon Taff Sure Start studies or drawn from the resultant reports include:

- The finding that a number of families using services had complex needs, yet the majority (>80%) were discharged from services after completion of initial service
- Concern about whether services were reaching all potential users, particularly socially excluded families and children
- The finding that no objective measure of children's progress was included
- The finding that little evaluation had been done of the networking within Sure Start services or with other services and agencies, i.e. whether families' comprehensive needs are assessed and referrals made to further relevant services
- Concern that although some services have been the subject of formal evaluation, routine evaluation of other services is not detailed or comprehensive

3.6. Conclusion:

This chapter looked at how the implementation of social policies in the UK since the eighteenth century led to improved welfare services and increased well being for many UK citizens. It also discussed how regardless of this, successive governments failed to achieve a 'social utopia,' a situation demonstrated by the continuance of poverty, social inequality and child poverty into current times.

Consideration then turned to the end of the twentieth century, a time which saw the election of a government whose stated intents included addressing social inequality and providing better opportunities for citizens particularly those living in deprived communities. The early work of this 'New Labour' government included an assessment of ongoing child service provision. This exercise identified inadequacies within UK children's services, and included a review of early intervention programmes in the USA and the UK which appeared to have a beneficial impact on the development of disadvantages children. The government response included the establishment of Sure Start - an early intervention programme focused on improving the well-being and development of children, families and communities in deprived areas. NESS evaluations to date are, after some disappointing early findings, suggesting the work of Sure Start is now having some positive impact on children and families living in their areas carried. However, even with such encouraging findings NESS reports comment on future challenges e.g. the differences in the effectiveness of individual SSLPs, and the problem of promoting service use by hard to reach or vulnerable families.

Consideration of Sure Start in Wales required a discussion of child policy and strategy in Wales since Sure Start began in 1999/2000, and appreciation of how Sure Start in Wales has been merged with other early years services in recent years to become part of a National Service Framework in Wales. Despite this, Sure Start still exists in Wales, in local programmes such as Rhondda Cynon Taff Sure Start. Previous evaluations of RCTSS have reported that service user satisfaction is high and that the projects are impacting beneficially on those children and families. However these conclusions were drawn from service user feedback and report, and no systematic record of service use and effect had been used. In addition early evaluations identified some concerns were also identified: firstly whether the services were reaching or meeting the comprehensive needs of families especially those deemed 'hard to reach'; and additionally whether services are impacting beneficially on the development of children and families. These concerns require further research to explore the work of the Rhondda Cynon Taff Sure Start agency with families who use their services. It is argued that such work would be aided by a focus on the theoretical basis underpinning the Sure Start programme, and y af framework or model which shares this base and could be used to guide the present study. The next chapter will therefore review theoretical approaches to child development and models of early intervention programme provision.

CHAPTER FOUR: Theories and Models of Child Development and Early Intervention.

4.1. Introduction

Despite current belief that a child's development can be affected by the interaction of forces from nature and nurture, and some children can be helped and supported by early interventional services, historically the field of early intervention has been patchy and inconsistent with conflict between different models, goals, targets and philosophies (Richmond & Yacoub, 1993; Brookes-Gunn, 2003). Sure Start is a relatively recent interventional programme with clear principles and goals which demand ongoing evaluation(s) of service provision, effects and outcomes. Guidance for Local and National English Sure Start evaluations (ness.bbk.ac.uk), initially appeared to place responsibility for process evaluation with SSLPs and outcome evaluation with the NESS team, although it must be acknowledged that many more local reports and recent evaluations of English SSLPs (e.g. Anning *et al.* 2007) have explored local service effects. However, this present study, which began in 2004, has not been part of, or limited by, any national direction or research as no Welsh Sure Start national evaluation was/is being conducted or planned.

Developmental theories or models can be found embedded within early intervention approaches, as has been explained by Richmond & Yacoub (1993):

> *'An exploration of historical roots includes theories and practices developed over the last two centuries in early childhood education, child development, pediatrics and social welfare. Each of these areas represents a strand of theory and practice that is being woven into the early intervention philosophy'*
>
> *p.1*

With this in mind, this chapter begins by exploring the theoretical roots that appear to underlie early intervention programmes such as Sure Start, before reviewing theoretical models that could offer guidance to the present study: in both planning and in the interpretation of the study's results. This makes the search for a model of early intervention programme provision which shares with Sure Start the aim of promoting positive developmental changes in young children, but which also details and recommends a process of service provision and so provides pertinent areas for evaluation within its framework. To identify such a model or theory this chapter intends to:

1. Briefly review theoretical approaches to the study of child development;
2. Consider the theoretical approach closest to the principles of the Sure Start programme;

3. Discuss the components needed in a model with this common approach
4. Identify a model which appears best suited to work of the present study.

4.2. Theoretical approaches to child development.

Child development text books give clear descriptions of the characteristics of a child's development, and of the processes believed to underlie this development. They also cover the relevant hypotheses about child development presented through a variety of perspectives which act like different lenses through which to view and promote the study of human minds and behaviours. Rather than conducting comparisons of all child development theories, this section will consider child development theoretical approaches while keeping the aims and principles of Sure Start and the purpose of the present study central.

Chapter one considered the nature/nurture debate before concluding that current opinion supports the integration and indivisibility of the two fields in relation to child development. When considering the philosophy of models of development this has been addressed as 'split' versus relational or organismic issues. The split concept is linked to mechanistic theories within which nature and nurture processes are divided, with one process (nature or nurture) being of primary importance, while organismic theories see nature and nurture as more entwined and interactive throughout life (Overton, 1998). The following section will briefly describe the concepts of mechanistic and organismic theories before continuing to consider more deeply the concept of developmental contextualism or developmental systems theory. The Developmental systems approach supports the organismic theory, and synthesises the influences of nature and nurture with forces with contextual ones (Lerner, 2002).

a. Mechanistic theories of development.

All mechanistic theories arise from split ontology, as mechanism reduces all phenomena to one common constituent level which precludes the existence of two different levels of influence on a person's development (Lerner, 2002). This approach gives the child little role in shaping their own development (Slater *et al.* 2003). In a mechanistic model, human functioning is reduced to core elements e.g. stimulus-response connections in nurture, behaviourism, genetic determinism. This mechanistic perspective has been criticised because is does not account for higher, more complex levels where new

qualitatively different characteristics emerge, characteristics that did not exist in and therefore cannot be reduced to a lower level. It has also been argued the mechanistic model fails to account for the nature of the different phenomena present at all levels of analysis,

> *'it allows no qualitative discontinuity, no newness, no emergence, and no epigenesis within the perspective. Only quantitative differences may exist.*
> *Lerner, 2002, p.62.*

b. Organismic theories of development.

The emergence of new characteristics allows a developing organism to pass through different stages of development and experience qualitative structural changes which result in the presence of new phenomena. This view is represented in the holistic organismic philosophy of science, which sees an organism as composed of a system of parts that works together and are affected by each other (Lerner, 2002). The underlying principle of organismic stages of development can be found in the theory of Piaget, who proposed humans construct their own worlds through goal directed activities, processes which result in emergent behaviours in different stages e.g. as demonstrated in tasks in which children behave quite differently from adults, (Light & Oates, 1990). Within this organismic or pre-determined epigenetic view, nature provides the ultimate goal for activity i.e. full development, and pulls the organism towards its final end state. Causative agents such as the context surrounding the individual are seen as - at best - secondary influences as they can speed up - or slow down - the overall process, but cannot change the developmental sequence or goal involved. This has been challenged by theorists who emphasise context-associated variations found in the development of organisms, and question the inevitability and finality of the development process (Lerner, 2002).

c. Contextual theories of development.

From a contextual or probabilistic epigenesist perspective the emphasis is on the transactional relationship between the developing organism and its context, and on the plasticity of an individual throughout life. This view opposes both the mechanistic and predetermined epigenesist schools of thought, as it proposes developmental changes are made by the complete systemic integration of nature and nurture which provides the base for multiple interactions which can create qualitative discontinuity and sets no final goal or cause. This means an organism's exogenous and endogenous environment must

always be considered when trying to understand developmental changes, with the emphasis on the relationship existing between characteristics of the organism and the features of its context (Lerner, 2002). This concept agrees that nature and nurture are intrinsically linked, however it has been argued that contextualism alone with no final goal could imply continual, pointless change, unless placed within the context of human development:

> *'whereas the 'pure' contextual view of plasticity is not empirically or logically useful, when teleology is rejected and/or a state of tension is postulated between influences that promote multidirectional changes and influences that promote integration, a developmental contextual conception is reached. .....thus, developmental contextual conceptions emphasize the probabilistic characteristic of development and in doing so admit of more plasticity in development than do predetermined-epigenetic conceptions.'*
>
> *Lerner 2002, p.73*

To overcome the limitations of 'pure' contextualism or 'pure' organism approaches Overton (1984), suggested a merger of the two concepts into what he termed 'contextual organism' and others have called 'probabilistic epigenesis' or 'developmental contextualism', an approach which produces a new concept. In this concept, although the context influences an organisms development, this influence is restrained by the organisms characteristics, i.e. the individual and its context i.e. biological, individual-psychological and socio-cultural and physical- ecological levels of organisation, exist in a dynamic relationship where each affects the other. Overton (1994b, cited by Lerner, 2002) suggests that the integration of action – of the individual on the context and of the multiple levels of the context on the individual - constitutes the process of development.

It is possible to group these relational dynamic theories under the label of 'developmental systems.' The developmental systems perspective adopts a theory that defines a human being as an embodied person functioning as a dynamic system of cognitive, emotional and motivational meanings, and so allows the exploration of development as a product of mutual interactions between genetic expression and its environmental context (Coll *et al.* 2004). This theoretical perspective is one which supports both current opinion and the evidence from early intervention programmes cited earlier. Firstly, in that the interaction of forces from nature and the environment has the power to influence the pheno-typical outcomes of existing geno-typical possibilities, and additionally that appropriate governmental policies can, by influencing the environments and experiences of families

and young children in many ways - including early intervention strategies and interventions - work on preventing and remediating problems and delays in children's developmental progress and outcomes. This of course, relates to the theoretical base of Sure Start.

4.3. Developmental systems in relation to Sure Start.

The developmental systems approach with its integration of biological, individual, social and ecological influences on the process of development, and appreciation of the dynamic interaction of an individual and its context, is one illustrated by early intervention programmes such as Head Start and Early Head Start. The probability that Sure Start shares this approach is suggested by the way the programme was planned and developed as well as by work conducted by local programmes and in findings drawn from the NESS.

As previously stated, Sure Start was formed in response to governmental recognition of a societal need i.e. the need to promote the development of children living in areas of disadvantage by improving their experiences and environments. Chapter 2 (p.16) reviewed Bronfenbrenner's concept of 'nested' societal levels, each of which contains developmental factors that exist in a dynamic relationship i.e. changes in one factor can affect the role of other factors, both within and between each level. Sure Start appears to share this theoretical base as it aims to produce changes in individuals, communities, and ultimately in society, through the work of local programmes whose purpose is to alter and improve the environmental contexts and experiences of service users at individual and community levels. A recent NESS publication describes Bronfenbrenner's model as influential:

> *' the introduction of SSLP's in 1999 presented a significant shift in the way family life with very young children was regarded by central government in the UK. Hitherto this had been largely a private space in which intervention was not a normal occurrence unless some crisis of health, child protection or family failure had occurred. The SSLP approach, however was to be universal, proactive and preventative, to change the way parents in deprived communities reared young children.*
>
> *The intervention also reflected a general shift in conceptual models underpinning policy reforms in the US and UK. An ecological approach to understanding child, parent, family and community functioning had also been influential. For example, Bronfenbrenner's model of child development emphasised the historical/cultural influences on children's experiences of*

services and the psychological and structural factors shaping their parent's experiences.'

Anning & Ball 2007, p.97

This ecological approach was also apparent in guidance for local programme planning, which called for the consultation, inclusion, and engagement of individuals, communities and organisations. The rationale was that such consultation would help identify specific local need and thus provide services in a flexible, responsive, inclusive way which recognised and met the cultural and local sensitivities of areas and individuals.

In practice, it appears that Sure Start recognises that service provision must be dynamic and responsive and must address the multiple ecological factors that can impact on child development e.g. two generation education, parental employment, child care, parenting knowledge, local facilities, and the health and economic issues of individuals and families. Sure Start also seems to take account of the role of service providers and users in facilitating or hindering potential developmental changes, as demonstrated by local evaluation reports (Chapter 3:4.b, p.55-56) which suggested that the characteristics of individuals, organisations and individual SSLP's can contribute to the relative success, or failure, of the whole dynamic system.

Recent evaluative reports from the NESS (Anning *et al.* 2007; Melhuish *et al.* 2007) demonstrate how variations in SSLP programme delivery can impact on the effects of services on the children and families using Sure Start. The NESS identified eighteen characteristics (itemised in Table 4) as being central to proficient programme functioning and which should therefore lead to better achievement of Sure Start goals (Melhuish *et al.* 2007).

Table 4: SSLP Proficiency:

Domains of SSLP Implementation Proficiency
Process • Partnership-composition: the SSLP partnership board has a balanced representation of education, social services, health, voluntary and community organisations and parents • Partnership-functioning: the partnership functions well • Leadership: the SSLP has effective leadership/management • Multi-agency working: the multi-agency teamwork is well established • Service access: clear pathways to access specialist services • Staff turnover: staff turnover is low • Evaluation use: the SSLP takes account of evaluative findings
Progress • Services- quantity: Service delivery reflects guidance for core services in family support, health, play, early learning and child care. • Services – delivery: the SSLP has a balanced focus on children, family and community. • Identification of users: the SSLP has strategies for the identification of users. • Reach: the SSLP shows a realistic and substantial involvement of families. • Reach strategies: the SSLP has strategies to improve and sustain the use of services. • Services-innovation: the SSLP shows innovation in service delivery. • Services flexibility: services accommodate the needs of a wide range of users
Holistic • Vision: the SSLP has a well articulated vision relevant to the community • Empowerment: the SSLP procedures create an environment that empowers users and staff. • Communications: communications reflect the characteristics/languages of the community • Ethos: the SSLP has a welcoming and inclusive ethos. from Melhuish *et al.* 2007, p.159

The emphasis - as shown by the characteristics selected - on the importance of children, families, communities, interagency partnership and services, service access, empowerment and an inclusive ethos suggests that a ecological systems approach is advocated, as it calls for consideration of factors from wide ecological levels – which can impact on a child's experiences and development – when considering the efficacy of

SSLP's. The whole Sure Start programme or system is set in a developmental context, as its overall intent is to achieve developmental progression and changes in service users, particularly in young children growing up in Sure Start areas. Collectively, the above evidence suggests a developmental contextual approach has been adopted by the planners and service providers of Sure Start. Therefore the logical theory or model appropriate for this study would be one shaped by this philosophical approach, i.e. within developmental systems theories, but one which incorporated the role of interventions in changing systems in a way that impacted positively on child development.

4.4. Developmental systems theories and models.

When applying systematic theories to child development the belief is that the environment a child develops in is shaped by the interaction of a system of multiple forces, i.e. although the family is the core setting for a child with or at risk of disability, the family is also situated in other systems, e.g. parental support systems, employment systems, communities, systems of personal and cultural beliefs and the larger policy and resource environment (Warfield & Hauser-Cram, 2005). This calls for a developmental systems approach in the field of early intervention which allows child development and associated forces to be considered in relation to an early interventional programme. To allow SSLPs to address the specific needs of communities the Sure Start principles demanded that a suitable model be non-prescriptive in relation to the actual services provided, but there are still components that would be needed within a developmental systems model of early intervention that would be suitable for the present study. These are considered below.

a. Essential Components.

This study intends to explore concerns raised by earlier evaluations. These concerns are related to the whole process of service use, i.e: the ability of RCTSS to reach potential service users; to recognise the full needs of children and families using their services; and the ability of RCTSS to meet such recognised needs. This requires an exploration of the work of RCTSS from the time of first contact with potential service users and throughout the subsequent process of service use. For the purposes of this study, a model which sets out an effective process of early intervention service provision within which the services provided by RCTSS could be placed would be invaluable. Such a model could also act as a referral point when analysing data, as it may ease identification of the areas

of service provision that need evaluation, and in turn help point out current RCTSS practices which appear to facilitate or hinder effective service provision. To meet the above objectives the required model should incorporate the whole process of using a service, i.e. the referral or the route into service use, the process of service provision and the effects of service use, in a way that shows how these components interact with one another, with the individuals involved, and includes all the existing developmental forces capable of operating on the child and family involved.

> *'Establishing a comprehensive model of intervention, which integrates health, social care, and educational interventions within a common protocol, has been challenging. There is recognition that although some children have very complex needs, they and their families will nonetheless need interventions which take account of wider child development and family functioning.'*
>
> *Carpenter and Russell 2005, p.456*

The following section will consider the relevant components that would be needed in an appropriate model or framework to guide the present study and in doing so will draw on two sources for guidance. Firstly the recommendations of Ramey and Ramey (1998) that early intervention should include: the comprehensive assessment of the child/family's strengths and needs; the provision of appropriate supports and services; active monitoring and re-evaluation as the child develops. Secondly, on Anning and Ball (2007) who commented on the effectiveness of the Sure Start approach when working with families with additional needs and activities through: whole population screening, the diagnosis of needs, and appropriate interventions. Having considered these components, attention will be given to the over-arching principles within which a developmental model must operate.

i. The route into service/referral: As discussed earlier, Sure Start is a national programme which aims to provide multi-agency, universal support systems for families with young children in disadvantaged communities (Carpenter, 2005). The audit of services involved in Rhondda Cynon Taff Sure Start (Boot and Macdonald, 2004) showed how some services target or are available for varied and different families, e.g. some focus on young parents, or on parents who have lived in care, or who are living with mental health problems, whilst others provide community services such as mother and toddler groups or toy libraries that could attract service users from many walks of life. The route into

service use therefore varies: some users are referred by health, educational or social care workers to meet professional concerns, or to meet the concerns of patients/clients, other service users self refer to services to meet personal concerns, whilst still others use community based universal services and activities on a 'drop in' basis. The initial referral can be the consequence of routine health screening and contact, local awareness, contact for specific health, social or educational reasons, use of other services, or by chance. For potential SSLP users, the recommended practice of making contact with all families with young children in Sure Start areas should ensure that an opportunity for some level of contact or screening is routine. A route into service/screening or referral component therefore seems a logical starting point of a suitable developmental systems model of early intervention, especially as strategies for the identification of service users has been associated with effective services (Melhuish *et al.* 2007).

ii. Assessment: The provision of interventional programmes in areas of deprivation is based on the knowledge that interventions can address developmental risk factors and prevent potential disabilities or delays as well as ameliorate established problems. Use of some strategy to identify families who would profit from intervention, or some assessment has been recommended (Ramey & Ramey, 1998, Melhuish *et al.* 2007). Early contact can also be used to put developmental disabilities/risks in context by increasing knowledge of the child and family's lives and environments. Sure Start services are universally available within the community/neighbourhood or district concerned, and it is recognised that comprehensive assessments may not be called for or appropriate for all service users or services associated with Sure Start. But the need for children living with increased risk or actual disability/delay to have a full assessment of development risk factors still exists as it may lead to a better recognition of needs and so enable service provision to meet them where necessary. A relevant framework for the assessment of risk factors and disabilities should acknowledge all factors that can interect and affect child development, factors that can originate in many societal levels.

iii. Service provision: As discussed in section 3:3, the guiding principles of Sure Start (section 2.3.b.i.,p.52) demand that the services be locally driven, flexible and able to address the multiple factors causing difficulties in communities and families. Ramey and Ramey (1998), and Anning and Ball (2007) all comment on the need for services to provide families with appropriate interventions. In practice this requires provision of

multi-agency services to meet the varied needs of children, families and communities. A suitable model should also distinguish and be applicable to preventative and to 'treatment' services, and ensure interagency communication leads to input from multiple organisations and agencies to meet all areas of concern from one point of contact.

iv. Service outcomes: The point of early intervention programmes is to prevent or ameliorate developmental problems. Efficacy of interventions is often measured by outcomes in relation to children's development, but programmes can produce effects not measured by common developmental outcome measures, or may help children maintain developmental competence rather than make developmental leaps. A further problem of relying on statistical measures of developmental changes has been articulated by the NESS developmental team who suggested some progressions may be obscured by the lack of progress in others (Melhuish *et al.* 2005). This calls for a component in a developmental systems model that is concerned with effects or outcomes, but is flexible enough to identify all possible effects which may occur in many potential guises.

v. Monitoring: An additional issue is in the longevity of any outcomes associated with service use, or the 'fade out effect' of any gains. To ensure recognition of fade out, or a change in the situation of the family or child that affects the probability of problems or delays reoccurring, components concerned with reviews of outcomes and service provision and with monitoring, as recommended by Ramey and Ramey (1998), are required.

To summarise, this section has argued that a suitable developmental systems model for early intervention would need to encompass the following components:

- Route into service or referral
- Assessment
- Service provision: both preventative and secondary
- Service outcome/review
- Monitoring

These components can be seen as the building blocks required within an early intervention process which has been put in motion to bring about beneficial

developmental changes in children and families. The building blocks would be best depicted in a graphic representation of the change process (www.theoryofchange.org), therefore consideration now turns to some developmental models that include these components.

4.5. Developmental systems models in relation to early intervention services .

Bruder (2005) commented on an early intervention model of Elder and Magrab (1980) which emphasised the cooperation and actions of people and agencies as they worked together to meet a goal, but criticised it for failing to describe the amount and intensity of service coordination and integration needed in systems of early intervention. In England, the government have produced a framework which seems to build on this model as it emphasises the need for cooperation not only between agencies but with the people involved in service use and provision. 'Together from the Start' (DfES/Department of Health, 2003) gives practical guidance for people working with disabled young (0-3 years) children, and aims to move away from crisis intervention to planned, sustained early interventions (Carpenter, 2005).

'Together from the Start' is being implemented through Early Support, a programme based on the Sure Start initiative, with the intent of improving the delivery of services to families i.e. to integrate services for children, and promote the importance of professionals and families working together and sharing information across agencies (Ford, 2005). Early Support services include a family pack and accompanying professional guidance which sets out a clear framework of service delivery (Carpenter, 2005). The guiding principles of the framework, which can be found in 'Right from the Start: talking to families about disabilities' (DfES, 2004a, cited Carpenter 2005, p.27) are:

- professional training and development
- service improvement
- family support provision across boundaries

The actual framework includes: the provision of relevant information about the disability and relevant services; the referral of the child and family to multiple agencies who carry out an assessment of the family's needs; and includes parental consultation and

discussion in service plan formation and in later reviews of service provision. The continual consultation of parents, before and after service provision, regular review of family needs and the importance of multi-agency assessments along with the provision of a key worker, suggests this framework is based on a developmental systems perspective, but has been developed for very young disabled children and their families. This - together with the finding that the model does not relate to or include preventative interventions - suggests this model may not the best currently available to meet the needs of this study.

In a time when many vulnerable children and families are faced by numerous risk factors and developmental disabilities against a background of rapidly increasing knowledge of the science of early child development, Guralnick has developed 'A developmental systems model for early intervention for vulnerable children and their families', a model which connects developmental science and interventional practices, and promises to provide a framework through which to consider this study's questions.

a. The Developmental Systems Model for Early Intervention.

The Developmental Systems Model for Early Intervention (DSMEI) offers a framework which seeks to integrate current thinking about development, interventional science, and practices in a way which is both feasible and up to date (Guralnick, 2001). The following section will discuss how the principles of the DSMEI relate to the aims and context of Sure Start, before considering how the model components could meet the demands of the present study.

i. Principles underlying the DSMEI: Three principles, - the developmental framework, integration and inclusion – are closely related to the underlying concepts and approach of Sure Start. These are considered below.

- The developmental framework.

'The first and most fundamental principle of the developmental systems model is that all components are best organised within a developmental framework. The specific developmental framework presented here is one that has been directly linked to the main components of early intervention practice in a comprehensive approach relevant to children at risk for and those with established disabilities'

Guralnick, 2005, p.2

According to this developmental principle experientially based child developmental outcomes are based on three interactions:

1. The quality of child-parent interaction;
2. Family orchestrated child experiences such as toys, community activities, social interaction;
3. Providing for the child's health and safety e.g. nutrition, physical safety.

These interactions can be adversely affected by stressors which affect their quality. Stressors may be related to biological developmental risk factors or an established disability, and can include family information needs, interpersonal and family distress, resource needs or feelings about ability to deal with disability or risk factors, or environmental risk factors such as child characteristics, parental characteristics, parental beliefs and behaviours, economic considerations or lack of social support. These stressors can be found within in the ecological approach offered by Bronfenbrenner (1979), an approach which has been seen as influential in the formation of Sure Start (p.77). Consequently when working to promote children development from an ecological perspective, an early intervention programme such as Sure Start must recognise and meet stressors arising from cultural, social, psychological and biological levels, as these can shape the experiences of parents/children and thus impact on the development of the children. The DSMEI incorporates all such influential factors and places assessment and recognition of these factors, along with evaluation of the effectiveness of services to meet assessed needs within the process of service use.

- Integration: This principle recognises that multiples agencies need to work together to provide comprehensive intervention resources, and that this often creates interagency pressures that may adversely affect service provision and consequently fail to identify or meet developmental needs adequately. The need for interagency cooperation and integration exists in the DSMEI during the processes of: assessment – for diagnostic purposes, to identify stressors, and the compilation of the service plan – as well as in service provision arising from this assessment,

> *'the significance of efforts to address this issue cannot be overemphasised, as it is difficult to imagine that a system based on a developmental framework can be effective without well designed mechanisms that promote intervention'*
> *Guralnick 2001, p.5*

Reference to Table 4 (p.80) shows the NESS recognises that good multi-agency working can benefit the proficiency of SSLPs.

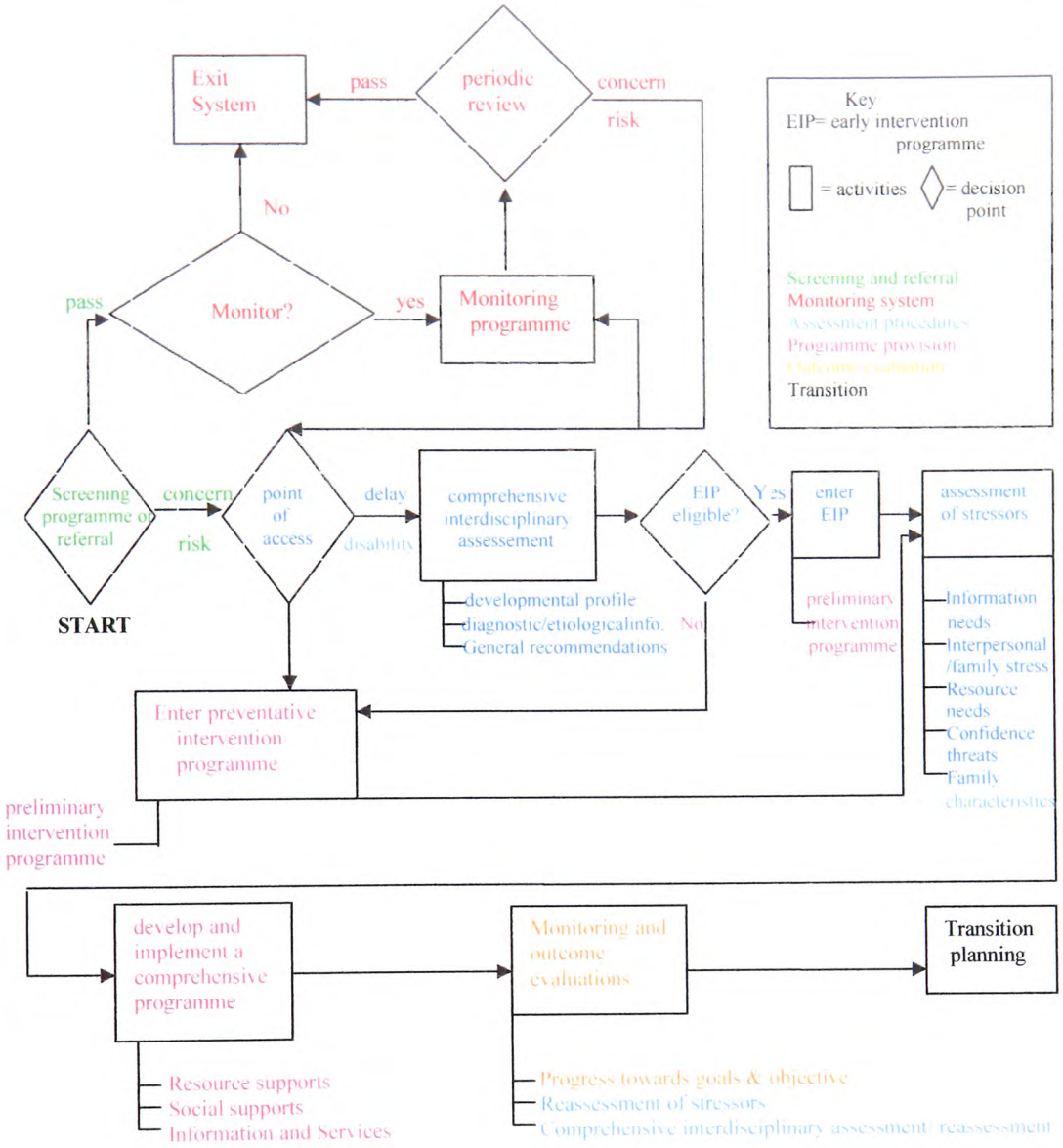
- Inclusion: Inclusion of communities and individuals has been central to Sure Start, and Guralnick adopted inclusion as the final governing principle for the DSMEI. Although it is a difficult practice to implement, the inclusion and participation of communities facilitates service use by ensuring that services are relevant, based in natural environments, and situated in accessible locations i.e. within the communities.

Having considered the guiding principles, attention turns to the components incorporated in the Developmental Systems Model for Early Intervention and their promise of effectiveness in an evaluation concerned with the reach and extent of the services provided by RCTSS.

ii. The components of the DMSEI.

The model consists of major components which include decision and action points (Figure 4). The intent is to place relevant developmental forces/stressors and the response of the early intervention system in relation to one another in a way which guides and allows a systemic relationship between these components. The model below has been colour coded to ease identification of different components and areas of service provision

Figure 4: A Developmental Systems Model for Early Intervention for Vulnerable Children



Guralnick, 2005, p.17

A summary of the components within the model can be found below. As pointed out by Guralnick (in correspondence with the author of this present study) each of these components is evidence based as it has itself been based on a series of studies.

1. Route into service use, screening and referral; As itemised earlier, a model applicable to early intervention programmes (e.g. EHS, Sure Start) services should have a component which reaches children at risk of developmental delays, or with established developmental delays or disorders. Gilliam *et al.* (2005) suggest the following process would provide effective identification of such children. Screening should be: early, periodic, and focused on all areas of child development; use instruments with adequate psychometric properties; be efficient in costs, time, personnel and accuracy; and should use a variety of instruments and approaches.

In the USA, federal education laws have made special education and early intervention services mandatory, and children qualify for intervention if they have delays in motor, communication, cognitive, social or self help skills, or have environmental or biological problems likely to lead to delay. It is recommended screening should be carried out at multiple points, e.g. in hospitals during the ante, peri or postnatal stages, within child care systems, when social services become involved, on entry into early intervention systems. Actual screening should include relevant demographic, economic, health and social factors, and may be best supplied as a tiered resource i.e. multiple gate low cost universal screening, with more formal screening for children identified as at increased risk of developmental problems. The follow up after screening should also be graduated, children at very high risk, or already delayed needing immediate referral to early intervention programmes, others with no apparent delay or fewer risk factors may need to be monitored to pick up any increase in risk or actual delays, whilst still others may be discharged from the system after screening. The whole process should be part of a coherent cross-discipline approach, avoiding variations in screening, diagnosis, communication and programme planning.

Sure Start works through provision of universally available services, and therefore a recommendation for regular periodic screening is not found within Sure Start guidance. However, Sure Start does recommend that contact is made with all families with young children in their areas, while Melhuish *et al.* (2007) list strategies for identification of users as a domain of SSLP implementation proficiency. When using the model as a guide, this first element directs attention to an objective of the present study, i.e. the reach of RCTSS Start, as it draws attention to the first contact of early intervention services with families. Interest lies in:

a. How the initial contact arose, and whether such opportunities are available and/or promoted for all families who may profit from RCTSS use.
b. How this contact is used by RCTSS staff. Is this used as an opportunity to discover whether the initial referral will meet all family needs or is some further assessment needed?

The other concerns generated by earlier evaluations of RCTSS are related to the ability of present RCTSS services to recognise and meet all the relevant needs of children and families using their services. The following components of the DSMEI draw attention to areas which deal with these issues and together make up the process of service use.

2. Point of access: The purpose of this component is to identify a family's needs and direct them to relevant services. A further aim at this stage is to assess and achieve some engagement of families. Harbin (2005) recommends an integrated and coordinated point of access at which meaningful participation of the families takes place. In the DSMEI the point of access component divides potential child service users into: those with a particular problem but no delay or high risk of delay; those not currently exhibiting delay but living with a designated level of biological/environmental risk factors who can be referred directly to a preventative programme; children with actual delay, suspicion of delay, or at very high risk of delay who will be referred for a comprehensive interdisciplinary assessment. Although this appears very prescriptive for Sure Start, in the present study this component can be utilised in a less formal way to direct attention to the engagement of families, and to whether service use leads to the recognition of all influential developmental factors from different ecological levels, and if multiple needs are recognised, more time and resources are offered to the family.

3. Comprehensive interdisciplinary assessment (CIA): Wolraich *et al.* (2005) comment that if children are deemed to be living with a disability or delay use of a coordinated interdisciplinary assessment avoids provision of multiple sources of information, and provides family with clear framework to identified goals, gives access to a variety of services and providers, and ensures a complete co-ordinated service.

In this context, although Sure Start guidance does not call for explicit assessments or assessment teams, Melhuish *et al.* (2007) promote established multi-agency teamwork,

and provision of flexible services as aspects that contribute to: more effective service provision; better accommodation of user needs: and suitable for the priorities of Sure Start. Interest in the present study will be in the ability of RCTSS to recognise and explore the extent of child and family need when a child or family member are experiencing problems at the onset of service use. This requires some analysis of the next component.

4. Assessment of stressors: Stress, which can affect family functioning and hence the child's development, can come from many levels of a family's environment (Bronfenbrenner, 1979) and may be related to:

- Information needs, (e.g. service access, teaching their child, financial information, information about delay disability (Bailey & Powell, 2005).
- Family characteristics, i.e. those which stress or support the family (e.g. parental attitudes, money, parental education/illness (Kelly *et al.* 2005)
- Resource needs, (emotional, material and information needs,(McWilliam, 2005)
- Interpersonal and family distress (e.g. parenting stress, parental depression, marital stress, social isolation and family cohesion, (Orsmond, 2005).

The need for SSLPs to combat stressors from such different levels can be found in the domains of SSLP implementation identified as contributing to proficiency by the NESS. These include:

- The need for multiagency working
- Service delivery reflecting guidance which requires services in the areas of family support, health, play, early learning and child care
- Services that accommodate the needs of a wide range of users.

5. Developing and implementing comprehensive programmes: Information gained from the assessment processes and knowledge of evidence based practice can be used by families and professionals, to develop a comprehensive programme (Guralinick, 2005). The planning process must use knowledge of the identified stressors, areas in which provision of support, information and services are needed, and tailor services to meet these needs. Service provision must then be carried out in a way that fits in with family

routines and maximises active family participation, and the core principles of inclusion, integration and co-ordination should be applied, (Guralnick, 2005).

Although no reference to the assessment or planning of individual programmes could be found in the literature consulted in relation to Sure Start, Melhuish *et al.* (2007) imply that comprehensive services capable of meeting varied family needs should be available, as their domains of SSLP implementation proficiency include those that look at: whether service delivery has a balanced focus on children, family and communities; reflect core services guidance in family support, health, play, early learning and childcare; the flexibility of services i.e. whether services accommodate the needs of a wide range of users. This study will be interested in the extent to which services that meet the needs of service users are provided, and whether service provison and planning is a 'one off' occurrence or part of an ongoing relationship between the agency and families.

6. Monitoring and outcome evaluation: After service provision the DSMEI moves to monitoring of the progress and outcome of service use. Warfield and Hauser- Cram (2005) provide a monitoring and accountability tier that if used can elicit a detailed account of the services provided including information about participants, staff, and the early intervention services themselves, some assessment of the quality of services and the perceived (as opposed to the objective) effects of the intervention. In order to provide feed-back to reform or improve the program, the tier finally addresses the outcome of the programme's intended effects. This part of the model fits well with the demand for the continued evaluation of Sure Start which accompanied the creation and funding of the programme.

7. Transition planning: The final component of the DSMEI is concerned with transition either to other services or out of service use. Transitions involve change and may create stress because it involves adaptations and adjustments to new circumstances. Many factors influence the degree to which a family accepts and implements any service suggestions. To help understanding of the complex process of transition Hanson (2005) sees four components as important:

a. Personal characteristics and experiences: The communication and interaction skills of all people involved in early years services, together with their personalities, goals and expectations.

b. Relationships between participants: the effectiveness of communication between families and services providers.

c. Procedural variables: Transition policy is integral in the USA. A written plan is stipulated at age 3 for eligible children. Service systems are required developing co-ordinated activities to support transition.

d. Amount and type of support: Support should be flexible as needs vary between individuals.

This study will focus on what happens when children and families finish their period of initial service use. Guidance in this area exists within the NESS literature:

> *'facilitating access to services is a longstanding theme in policy literature.....the continuum of access highlights five steps in linking families with SSLPs services that programmes seemed to use, to greater and lesser extent, although families could enter this sequence at other than the first point and did not pass through all points.*
> *1. Making initial contact with a parent*
> *2. Introducing a family to the service*
> *3. Facilitating the autonomous take up of at least one SSLP service*
> *4. Facilitating autonomous take up of more than one service, and*
> *5. Facilitating the autonomous uptake of services other than those provided by the SSLP.*
>
> *Tunstill & Allnock, 2007, p.86*

This recommended process of service use, which begins with increasing use of SSLP services and ends with transition out of sole use of SSLPs, is important as an important aim of Sure Start is to combat instances of social exclusion, and integrate people into their communities.

The consideration above shows that the DSMEI can be used to identify and frame areas of interest and analysis for the present study. Overall it was felt that the DSMEI met the requirements of this study as:

1. RCTSS services can be nested within the models' framework.
2. The model can be used to explore the concerns of the present study through the process of and outcomes of service use as experienced by service users.
3. Application of the model to Sure Start use may allow better understanding of areas where Sure Start service use promotes or raises barriers to changes likely to promote child development.

4.6. Conclusion.

The Sure Start programme seeks to incorporate and apply knowledge from the field of child development to the practice of early intervention. The above chapter considered various philosophical approaches towards child development, and identified the developmental systems approach as one shared by the Sure Start programme. A search for a developmental systems model which met the principles and the type of intervention(s) of Sure Start, resulted in the identification of the Developmental Systems Model for Early Intervention (DSMEI, Guralnick 2001, 2005). The principles guiding the DSMEI were explored and the components within the model described. This process showed that the DSMEI places constituent components in a way that follows service users from entry into service use, through use, to exit, monitoring or to a transition to other services, and does this in a framework that places services within a developmental context in an inclusive, integrated way which fits well with the aims of Sure Start. Guralnick has acknowledged that no comprehensive evaluation of the DSMEI approach exists, but also pointed out that the model is being replicated in part or in whole in many different communities (Gurlanick, 2005), and that a relatively comprehensive application of the approach has been used by at least one early intervention programme (Greenwald *et al.* 2006). The conclusion was that the DSMEI is a theoretical model which can be used as a framework for the present study. The next chapter will use this model in developing the methodology of the study.

CHAPTER FIVE: Methodology.

5.1 Introduction

The preceding chapters showed how a child's life – and environment – can impact on a child's development, and how changes in the environment and experiences of children can be affected by the attitudes, policies and actions of government. Sure Start is a policy driven, evidence based, national interventional programme formed with the intent of improving the experiences, environments - and hence the developmental outcomes - of children living in deprived areas of the UK. Sure Start is working throughout Wales, and Welsh local agencies are responsible for evaluating their own services. Findings from early NESS evaluations (NESS, 2005a) and from RCTSS (Hayward and Macdonald, 2003; Boot and Macdonald, 2004; Glossop and Macdonald, 2004) called for further research exploring the reach and process of service use. The previous chapter identified the Developmental Systems Model for Early Intervention (DSMEI, Guralnick, 2001, 2005) as a model providing a suitable framework for guiding this study.

This chapter begins by explaining more fully how the research questions and aims of the present study have arisen from earlier evaluations of Sure Start programmes. It then continues to draw on the study's questions and the DSMEI to consider appropriate methods for data collection and analysis. This section reflects on quantitative and qualitative methodologies before deciding that a mixed methodology should be employed. The chapter includes discussion of the specific methods and tools employed during data collection; the criteria set for participant selection; the practical and ethical issues which arose during the design and recruitment phases; and the process of participant enrolment, data collection and data analysis.

5.2. The nature and aims of the study.

Like other evaluations of SSLPs, previous evaluations of Rhondda Cynon Taff Sure Start found evidence of good practice but raised some important issues and concerns:

i. Hayward and Macdonald (2003) questioned whether all needs of child service users were recognised, whether parental information, concerns and support needs were fully met and whether interagency working could be improved.

ii. Glossop and Macdonald (2002) questioned whether some services reached 'hard to reach' families adequately, and noted that no objective measure of children's progress had been made. They commented that in practice a 12% failure of Child Care Workers gaining access to families had resulted in 200 failed child care worker visits during the months of their study.

ii. The audit of Boot and Macdonald (2004) found insufficient data was being recorded which had led to little evaluation, little evidence of service effectiveness, and denied the agency the opportunity to make informed plans for future development. The report also suggested greater communication between individual projects would help awareness of other agency personnel and their different roles.

The above findings and comments posed many questions that could be addressed in this study. Some questions, such as 'Do RCTSS services recognise and meet service user's comprehensive needs?' and 'Are hard to reach families being reached by/using RCTSS services?' are questions that can be answered by looking at the process or experience of service use. Other questions 'What impacts and effects can be associated with services,' 'Are services associated with the promotion of child development?' are related to the outcome of service use. This present study, which began in 2004, was able to ask both process and effect questions as Rhondda Cynon Taff is in South East Wales and was not therefore limited by the evaluation guidelines shaping earlier English local evaluations. The present study aims to discover whether RCTSS services are reaching the more disadvantaged children and families in the area; investigate whether service use can be associated with developmental changes in children during their time of service use; investigate the experience of service use for different participant families; and identify factors during service use which affect service use and outcomes. The DSMEI has been adopted to frame this study as this model frames the process of service use, highlights important areas of service provison, and supplies underlying, evidence based recommendations drawn from knowledge about effective interventions. The main objectives of the study are:

- To determine the developmental contexts of participant children and discover whether RCTSS services are reaching the more disadvantaged children in RCT who are at increased risk of developmental problems or delays
- To gain descriptions of participant's experiences of service use in order to discover if RCTSS service use led to the recognition and meeting of family needs which may affect child development.
- To report on the development of participant children during service use, and discover whether parents associated RCTSS service use with any perceived developmental changes.
- To compare participants experiences of the process of service use and identify factors which appear to mediate or prevent/limit effective services use
- To provide practical information to enhance the services offered by RCTSS
- To explore the process of applying the DSMEI to the services provided by a RCTSS.

To meet these objectives, information must be collected from representative families and children using Sure Start services. Data must provide:

1. Information about participant children and family needs, expectations, and situations before service use. This can be used to discover whether services are currently being used by disadvantaged families and whether service staff are recognising the different developmental needs of all service users. This information can also be used to place subsequent service use in the context of individual participant families and allow comparison of the experience of service use between participants living with different levels of deprivation.

2. Knowledge of changes in participant children's development and/or developmental environments during the families' associations with RCTSS. When considering this, it is appreciated that developmental changes can be measured in many ways some of which may not be demonstrated by quantitative assessment measures.

3. An exploration of the process of service use. Consultation of the DSMEI suggests tracking and comparing service use from initial contact until exit from use or transition to

other services would be appropriate, with: access into services; assessment; service provision; service review, monitoring; and transition being suitable areas for investigation. Focusing on these areas may also highlight the differing experiences and outcomes of participant children.

With the recognised importance of obtaining the opinions and perspectives of individuals (Bronfenbrenner, 1979) and concern about the lack of evidence of effectiveness from the perspectives of parents and children (Oliver & Smith, 2000) in mind, attention now turns to which methodology would be best employed to gather such data.

5.3 Qualitative, quantitative or mixed methodology?

When considering the methods that could be used in the present study it was noted:

> *'Sure Start Local Programmes (SSLPs) are both a social intervention and a complex one. There is as yet no firm consensus around the best methodologies to use to evaluate the outcomes either of social interventions or of those in which the details of the treatment can vary within the individuals and may be unknown to the evaluator.*
>
> *Meadows 2007 p, 65*

Reflection was therefore given to the information needed to answer the research questions of this study, and to the research methods and approaches appropriate when conducting an evaluation of a multifaceted intervention programme. Research questions were concerned with: the developmental context of participant children before service use; whether RCTSS services were reaching their target population; whether services were recognising and meeting the needs of services users; whether parents associated developmental changes in their child with RCTSS service use. In short, detailed information was needed about the experiences of families and children using RCTSS, before and throughout service use.

In relation to use of quantitative methods, conflicting outcomes of interventional child development programmes (e.g. Love *et al.* 2002; Melhuish *et al.* 2005; NESS, 2005a) have contributed to the ongoing debate about the efficacy of such programmes found at the start of the present study in 2004/5. Much of the debate is based on the scarcity of positive statistical findings from large scale intervention programmes, although more recent positive findings (NESS, 2008) have lent weight to the argument that such

programmes are beneficial. Despite the insight given by such evaluations, the sole use of such statistical methods for the evaluation of complex social interventions has been criticised because: findings may be particular to the context they were generated from and so lack external validity; of the possibility of control group contamination; the use of voluntary participants that can raise doubts about internal validity (Meadows, 2007).

Whilst not discounting the information that quantitative methods can provide, especially in studies that are purely focused on impacts or outcomes, this study's research questions primarily called for data which gave insight into the process of RCTSS service use. The next section therefore considers the use of a qualitative approach to explore the experiences and perceptions of service users during their time of association with RCTSS.

a. Qualitative methodology:

The re-emergence of qualitative research in the second half of the 20th century met growing concerns about problems of artificiality in research data, and increased interest in 'ecological validity,' (Hayes, 1997). Qualitative methodology encompasses many approaches concerned with human experience and is engaged in exploring, describing and interpreting the personal and social experiences of participants (Smith, 2003). Qualitative research challenges the positivist viewpoint that reality is something existing objectively in a shape or form independent of individual perception. In contrast, it acknowledges and works within the gap between the objective reality of objects and the subjectivity of different individual's representations of it. The importance of acknowledging the importance of individual interpretations was stressed decades ago by McNeill and Chapman (1985) who commented that individuals were active, conscious beings, aware of happenings in social situations and who were able to make choices about how they would act. This, argued McNeill and Chapman, meant that an explanation of an event or episode must include what those involved felt and thought about it. This argument supports use of a qualitative approach in this study, as it can link the feelings and thoughts of RCTSS users with their episode of service use. The appropriateness of qualitative methods for the present study is also supported by the work of Whitehead *et al.* (2004) who stated that evidence from studies of the reality of life in different kinds of households - about the decision making and courses of action taken by families - can

have powerful impacts on social policy, and of course Sure Start was formed as part of a 'New Labour' social policy.

This study sought a qualitative methodology able to recognise and document the individual agency of the families using RCTSS services, give insight into individual experiences of service use, and investigate the perceived effects of service use. The need to focus on the different perspectives and meanings of individuals suggested a phenomenological approach should be used. Phenomenology is concerned with how people live through, give meaning to and interpret situations, (Giorgi & Giorgi, 2003). Phenomenological research brings to the fore the experiences of individuals from their own perspectives, and the meanings given to and drawn from experiences in life. This approach would partially have met the needs of the study as the meanings attributed to the experience or effects of services are important. However 'pure' phenomenology employs a descriptive approach which makes no assumptions about causal factors (Orleans, 2005), while the present study explores the experiences and effects of service use from an approach that focuses on the causative role of environmental factors in child development. An additional problem is that phenomenology uses no specific hypothesis or theory (Giorgi & Giorgi, 2003) and the DSMEI is based on developmental systems theory, while the hoped for perceived benefits of Sure Start are based on the theory of change. When looking for a methodology that incorporates phenomenology but allows meanings to be set in context, the ability of individual narrative accounts to focus on individual meaning and experience gives narrative, specifically narratives about personal life stories a means for:

> *'another to step inside the personal world of the story teller and discover larger worlds'*
>
> *Atkinson 2007, p.224*

This suggested that narrative research would be a suitable method for this study. Narrative is able to gain insight into the context of the families using services, obtain the 'story' or experience of service use as interpreted and presented by participants, and be used as an analytic tool to study and interpret the data.

i. Narrative method.

Narrative research theory proposes that narratives are holistic throughout life. We are born into a storied world, live through the creation and exchange of narratives, and after death are described in terms of narrative which:

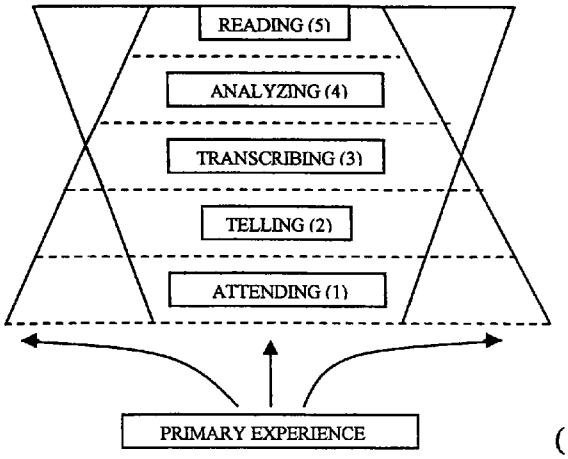
> *'.....is concerned with the human means of making sense in an ever changing world. It is through narrative that we can bring a sense of order to the seeming disorder in our world, and it is through narrative that we can begin to define ourselves as having some sense of temporal continuity and as being distinct from others,'*
>
> *Murray 2003, p.111.*

When considering narrative as a data collection method it is important to appreciate one theoretical position of narrative. Narrative can be used to explore psychology's interest in the behaviour of beings and in the investigation and understanding of their inner worlds, as one of the clearest routes for learning about inner worlds is through the verbal accounts of narrators telling stories about their lives and their experienced realities (Lieblich *et al.* 1998). Narrative research can approach the self in a comprehensive way through autobiographical narratives in which people tell about their lives, an activity which appears to be a universal pastime used throughout life by people from all social backgrounds in many settings (Reissman, 1993). Use of a narrative approach in this study may increase understanding of the process, the individual reality of service use for participant families, and of how individuals worked the experience into their lives.

> *'The basic principle of narrative psychology is that individuals understand themselves through the medium of language, through talking and writing, and it is through these processes that individuals are constantly engaged in the process of creating themselves,'*
>
> *Crossley 2000, p.10.*

When considering the issue of reality, Reissmann (1993) observed researchers never have direct access to another individuals experiences, but must deal with ambiguous representations, thereby making any attempts to be objective and neutral impossible. In support of this argument she presented a model of five levels of representation which exist in the narrative research process, (Figure 5).

Figure 5. Levels of Representation in the narrative research process



(Reissmann 1993, p.10).

Figure 5 shows how the process of telling, representing and analysing accounts involves repeated 'alterations' during successive stages and is limited by the language used, the 'parts of events' chosen to recount, and continual interpretation of meanings given to them. Through the research process both the interviewed and the interviewer contribute to a progressive removal from the reality of the events, towards subjective realities.

> *'all forms of representation of experience are limited portraits. Simply speaking we are interpreting and creating texts at every juncture, letting symbols stand for or take the place of the primary experience to which we have no direct access. Meaning is ambiguous because it arises out of a process of interaction between people: self, teller, listener and recorder, analyst and reader. Although the goal may be to tell the whole truth our narratives about other's narratives are our worldly creations'*
>
> *Reissmann, 1993.p.15*

Although it is still argued that narrative is an appropriate method for this study, the awareness that levels of representation may alter accounts, means caution and care must be exercised during listening, transcribing and analysing. However, this does not alter the power of narrative research to generate data about the world as it exists in the mind of the participant. The importance of this is stressed in Bronfenbrenner's (1979) use of the rationale of Lewin, which argues that the environment of greatest relevance when trying to understand the development and behaviours of individuals is reality - as it exists in the minds of individuals - because when individuals define situations as real they are real in their consequences. Services provided by Sure Start have been planned by programme managers, and implemented by service providers with the shared aim of improving the lives of children and families, but the subjective reality of programme use - as

experienced by service users - may differ from the intent of planner and providers. It is this experience - the reality of Sure Start service use for service consumers - which is the area of interest for this study as it becomes the resultant factor or force which impacts on the working of the agency, the family system of those using the agency, and ultimately the subsequent development and behaviours of those involved.

ii. Narrative analysis

Once data have been obtained, they must be interpreted and analysed, a process helped by an understanding of the different structures or models that have been applied to narrative and used to direct the analytic procedure. Narrative can be analysed many ways e.g. content, structure, style of speech, motives, attitudes, the beliefs of the narrator, cognitive levels; (Leiblich *et al.* 1998). A variety of structures have been used, and Mishler (1995) offers a typology of models that clarifies differences amongst structural approaches by focusing on three different problems that have been defined as the main task for narrative research analysis (Figure 6).

Figure 6. Models of Narrative Analysis; A Typology

1. Reference and temporal order; The 'telling' and the 'told'
2. Textual coherence and structure: Narrative strategies
3. Narrative functions: Contexts and consequences

Adapted from Mishler 1995, p.90

The first category is interested in events and their time relationship, i.e. the temporal ordering, the second with the textual representation or form of narrative, and the last with narrative's work or what stories do i.e. their actions and meanings in the settings they occur in and the effects they have. One purpose of this typology was to draw attention away from the idea of a 'best' way to use narrative, and to promote the many ways available to study and define narrative thus encouraging the exploration of different approaches, and strengthen research by employing inclusive strategies that would:

> *'provide a more comprehensive and deeper understanding of how narratives work and of the work they do.'*
>
> *Mishler 1995, p.177.*

The present study is interested in the temporal order, on the sequencing and linkage of events, and the possibility of change over time. It seeks to use the material in a holistic way, where the story of the person is taken as a whole and parts of the text interpreted in the context of other parts of the narrative. This approach is preferred when a study wishes to explore an individual's development to their current position or state (Leiblich, 1998). It also gives narrative the ability to provide directionality within a series of otherwise isolated events, by structuring them in a way that generates coherence and a sense of movement though time (Gergen & Gergen, 1984). Sure Start's aims, or goals, i.e. to engender positive changes over time in communities, families and children through the provision and use of relevant services, makes use of the temporal element of narratives an appropriate way to gain knowledge about the perceived effects of service use. However narrative is also able to describe the context of the family, the child's situation and environment, and to investigate the function, sense and meaning given to services, and the positive or negative impact of factors from personal, interpersonal and other societal levels on service use. To answer the research questions of this study the temporal order will be explored to look at events over time, but the function of narrative will also be investigated to look at what happens to and for individuals during service use.

Gergen and Gergen (1984) argue that the description of social conduct across time usually takes place through use of narrative which possesses certain properties and basic forms. They view two related properties as critical to the ability of narrative to give both connection and direction to events through time. Firstly, the account must have a goal or end point, and secondly, with this in mind, the narrative must choose and arrange the events leading to this end in a way that makes such a goal probable. Gergen and Gergen claim this approach makes events unrelated to the goal detract from the narrative, an approach advocated by Greene, (1995) who supports the idea of studying text through macrostructures, i.e. short summaries which eliminate detail and emphasise main points, and Murray (2003) who states that making a summary is a useful early strategy during analysis to aid: the identification of narrative beginning, middle and ends; key issues in the text; narrative linkages that connect different parts. This technique helps the analytical structure of Gergen and Gergen (1984, 1986), which identifies three prototypes which they propose organise narratives;

'If the successful narrative is one that arranges a sequence of events as they pertain to a particular goal state, there are only three prototypical or primitive narrative forms: those in which progress towards the goal is enhanced, those in which it is impeded, and those in which no change is made.'

1984, p.175.

The three prototypes have been termed

- Stability; no change is made
- Progressive; progress towards goal made
- Regressive: movement away from goal

The stability narrative prototype (Fig. 7) is found in narratives that show little or no movement towards the identified goal. This can occur at any level on the evaluation key, i.e. the individual may feel things continue to be good or bad, but over time it shows the position of the narrator as unchanged in relation to the goal. The other prototypical forms link events in a way that shows time related evaluative movement (Fig. 8). A progressive narrative prototype shows movement towards the goal, while a regressive narrative indicates movement has been away. Murray (2003) describes this threefold categorisation as useful, but cautions analysts to apply it flexibly, in order to recognise shifts from one prototype to another in narrative accounts, and to identify times when goals are altered, so events originally classed as one prototype, may become another .

Figure 7. Positive (+) and negative (-) stability narratives.

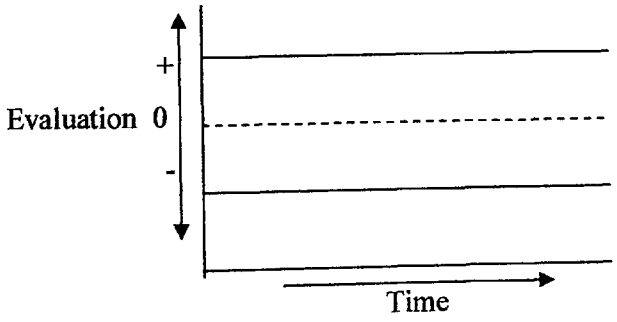
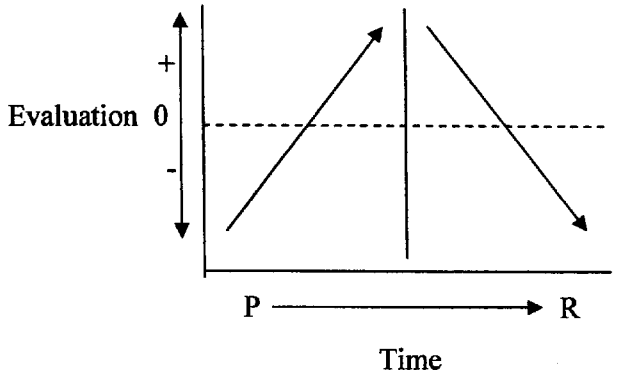


Figure 8. Progressive (P) and regressive (R) stability narratives.



adapted from Gergen and Gergan 1984, p.177.

Use of Gergen and Gergens's model to interpret and analyse data can aid conceptualisation of the whole process of service use. This would begin with the starting point level i.e. 'pre-service use' child developmental levels, their home based developmental environments, and their route into service use. The next part of the process is participant families' experiences of service use. With the 'end' point the perceived outcome of service use i.e. participant's perceptions of changes in their child and/or in their child's developmental environment which they associate with services. This enables the investigator to follow the 'journey' of participants and find out whether participant's narratives present service use as being progressive, regressive or having no effect on movement towards any identified goals. In this way the narrative prototypes link the incidents or concepts with the goal and provide an evaluative position for the narrator.

This initial analysis only answers some of this study's research questions, those related to the perceived effects or outcome of service use. To consider questions about the process of service use the function of the narrative must be investigated. This study has adopted the DSMEI (Gurlanick, 2001, 2005), a model which provides a guide for relevant areas within early intervention programmes where analysis of the function, work or role of services can be explored. The need is for narrative which describes the developmental status and context of child participants before they use services, and which gives information about participant family's experiences of service use relevant to the areas provided by the DSMEI. This information would help discover whether services are reaching vulnerable families, whether family needs are being recognised and met, and

could help identify barriers and mediators of effective service use. Narrative accounts may also reveal the attitudes of service users towards services, as well as the meaning of service use for different families. The analytical guidelines are described in more detail later.

Having decided that a qualitative narrative research approach was suitable for this study, a further question arose: could the additional use of quantitative methods improve on the information and knowledge gained by use of qualitative methods in this study? NESS guidance given to local Sure Start evaluations was consulted, and attention given to advice that mixing quantitative and qualitative data collection methods can result in statistically useful and contextually illuminating data (Harrington *et al.* 2005). But whether this advice was pertinent to this study appeared debatable: only two researchers were available for data collection; the data collection – using a narrative approach – promised to be timeconsuming; use of narrative dictated small sample sizes and therefore made use of statistical analysis limited. The real query was therefore whether collecting quantitative assessments of participant children's development during their association with service use would add anything to this study's findings.

b. Quantitative methodology.

The goal of this study was not to identify a 'cause and effect' relationship between service use and participant children's developmental progress. Despite this, the need to investigate more systematically whether RCTSS services are affecting the developmental progress of children had been recognised by earlier evaluations in RCT, and could not be ignored. As discussed earlier, the validity of randomised control trials when used as a method of evaluation in complex social interventions has been questioned. Indeed, even if this study's resources had made quantitative assessment a feasible primary method of evaluation, its use may have been particularly difficult within Rhondda Cynon Taff as many other statutory and voluntary agencies exist within this county. To complicate matters of contamination even more, some of these organisations have large profiles in different areas of the county e.g. a Nurture school in Treherbert, On Track in Rhondda Fach, a Barnardo's family centre in Penywaun, and within many of these organisations RCTSS has a funding or staffing contributory role.

However quantitative data could be used on an individual basis to provide a more objective, comparative measure of developmental changes. Quantitative data could strengthen or challenge parental perceptions of changes in their child's developmental progress or environments, and/or detect concerns or changes not identified within participant narratives. Therefore the use of quantitative methodology was warranted, especially as the longitudinal nature of the study allowed time for reflection on any disparities between qualitative and quantitative findings and further exploration in later data collections. This study is also interested in the developmental environments of participant children over the time of service use. As factors impacting on children's development are usually based in home and community environments it was felt that pre and post service assessment of home environments, family interactions, and community involvement were also warranted in order to detect any changes in participant children's developmental environments that may impact or contribute to their developmental progress during their contact with RCTSS.

Although these quantitative measurements should help to clarify the answer to the research question 'has anything changed?', the question of what underlies any changes and whether they are due to or associated with the service use cannot be answered by sole use of these measures as this is a question of causation,

> *'questions about causation are usually the hardest to answer, especially in complex situations where initiatives are multifaceted and take place alongside other developments that may also effect change.'*
>
> *Coote 2005, p.9*

Therefore although the quantitative assessment promised to add to the knowledge gained by this study, the main focus remained on the qualitative element.

c. Mixed methodology.

Consistent goals have been presented in the above sections, i.e. to explore the experiences and effects of service use. The recognition that contributions can be made by both quantitative and qualitative methods, shows there is no place for polarisation between them:

> *'focus on methods of investigation should not lose sight of the significance of a distinction between quantitative and qualitative data.'*
>
> *Bryman 1988:127*

Use of a mix of methods makes sense to build a fuller, more comprehensive picture of social life and changes facilitated by policies and interventions. The use of multiple methods – triangulation – is advocated as it works from the principle that you get a better view by looking at situations from more than one direction (McNeill & Chapman, 1985). Indeed it can be argued that this diverse methods approach is particularly important in a study investigating whether a complex community based initiative has, from the perspective of people using the programme, 'worked', as these are situations in which no one method alone is likely to be enough (Coote, 2005). This study will therefore focus on the qualitative strand of research, whilst recognising the need for quantitative measures to complement, strengthen or question any qualitative findings through use of mixed methodology. The next section will discuss the methods of data collection and outline the tools used to assess participant children's developmental contexts, developmental progression and their home environments. The final section describes the phases and processes of participant recruitment, data collection and data analysis..

5. 4. Method.

a. Quantitative Measures.

i. Developmental assessments.

The development of healthy, normal children from stable adequate environments usually progresses in a predictable pattern. Research literature concerned with the developmental progress of children provides an outline of the usual developmental progress for the specified age groups (Sheridan, 1973). This has allowed the construction of tools to monitor developmental progress, by giving age related developmental levels for normal age progression.

For this study, instruments needed to have proven validity and reliability, be age related, appropriate for use with the age group of participant children, assess all the relevant developmental domains, and ideally have been standardised on British children. A number of well validated tools have been widely used by health and educational professionals to assess the developmental levels of infants and young children e.g. the British Ability Scales (Elliot *et al.* 1982), the Denver Developmental Screening Test (Frankenburg *et al*, 1962), and the Child Behaviour Checklist (Achenbach, 1983). However many existing assessments either failed to measure all necessary developmental

domains or could not be applied to the complete age range of study participants. Three suitable tools were identified, the Griffiths Mental Development Scales (Griffiths, 1967, revised edition 1984), and the Schedule of Growing Skills (Bellman *et al.* 1987, restandardised 1996), the Bayley Scales (Bayley, 1969) but after further consideration were rejected as they could only be administered by specially trained personnel, a method of data collection beyond the present study's resources.

A fast, inexpensive method to facilitate developmental screening of infants and young children, has been met by a parental questionnaire system named the 'Ages and Stages Questionnaire' (Squires *et al.* 1999). This was developed with two important uses in mind i.e. to provide a tool for use on large numbers of infants and children, and to monitor the developmental progress of children identified as being at risk of delay due to medical or environmental factors. The ASQ (Appendix C) consists of 19 questionnaires, each targeted at an age group between 4 and 60 months of age. The validity of the questionnaires is further extended as each may be used for ages one month either side of the specific age. e.g the questionnaire for infants aged 4 months old, may be used between the ages of 3 and 5 months, this makes ASQ suitable for the majority of children under 5 years old. The ASQ is designed to be completed by parents and scored by research staff. Support for the validity and reliability of parental assessment of their children's developmental levels can be widely found in the available literature (eg. Knobloch *et al.* 1979, Glascoe *et al.* 1989, Glascoe, 2003, Chen et al. 2004,). Concerns arising because the ASQ was developed in America, were alleviated by the finding that the ASQ has been used in studies performed in different areas of the Western world (Skellern *et al.* 2001, Jansen, 2003).

The ASQ contains a personal/social element, but like many developmental tools, does not comprehensively assess an important, relatively new, area of interest, i.e. the social and emotional development of children. Edmunds and Stewart-Brown (2004) discussed the growing awareness of the importance of children's social and emotional development, and claim this growth is historically evidenced in the way earlier instruments focused entirely on antisocial behaviour while more recent instruments recognise the emotional underpinning of behaviours. Their comprehensive review included many currently available instruments, but revealed that few are able to screen or assess the emotional,

social and behavioural development of children in the early age group of this study. Fortunately the principal authors of the ASQ have supplemented the ASQ with the construction of the 'Ages and Stages Questionnaire; Socio-Emotional Questionnaire' (ASQ:SE, Squires *et al.* 2003) which is a parentally administered assessment, similar in design to the ASQ, which allows the social and emotional development of children to be assessed in greater depth than through use of the ASQ.

The ASQ and the ASQ:SE were adopted for use by the study. During data collection both of these measures were used to obtain data before and after service use, information which was used to indicate whether focus children could be classed as developmentally competent or non-competent over the time of service use, and so help identify any developmental changes.

ii. The Home environment.

Discussion of environmental factors thought to mediate child development (Chapter 1: 4), identified influential factors within a child's home and local community. These factors are dynamically related in a systematic way which means a change in one factor leads to changes in the rest of the system, including the child's development (Bronfenbrenner, 1979). One way to gain some understanding of the existence and progression of these factors before, during and after service use is to quantitatively assess the home environment and community involvement of participants prior to service use, and track it over the time of service use. Bradley and Caldwell (1979) developed the 'Home Observation for Measurement of the Environment' (HOME, Appendix E). HOME provides a systematic description of the primary environment a child is brought up in, by scoring areas of parent:child interaction and the child's typical daily environment during researcher observation and interview visits carried out at home with the mother (or other primary care giver) and the child. These visits can be repeated at intervals to track any changes (Totsika & Sylva 2002), and the measure was used for this purpose in the present study.

b. Qualitative data collection.

Having decided that narrative is a suitable method to obtain information about the developmental context and the experiences of participant children and their families

during service use, attention turned to the best way of obtaining narratives. Offering stories about events and experiences is a human activity, within which research interviews are no exception as respondents often contribute for lengthy turns, organising accounts into lengthy stories (Reissman, 1993). Qualitative data are typically collected through focus groups, interviews, direct observation or written documents (Dunnagan *et al.* 1999). Narrative could have been accessed by methods such as focus groups, diaries or audiovisual techniques, but interviews allow issues to be explored to a greater depth and can draw attention to perspectives often unrepresented and undocumented (Banister *et al.* 1999). This, along with the possibility that confidence or literacy problems may have hindered use of groups and diaries by some potential participants, led to the use of interviews to engender narrative about family contexts, their experience of and perceived effects of service use. An additional pragmatic factor was that the meetings arranged for the interviews could also be used to conduct the quantitative assessments.

c. Developmental risk factors.

Although the HOME assessment (Bradley & Caldwell, 1979) and the narrative about participant families contexts, promise to provide information about the developmental context of participant children, a difficulty remained. Chapter one discussed at length factors associated with developmental delay in infants and young children, factors which may not be discussed or become evident during use of the other assessments. In order to ensure all necessary information was collected for participants before service use, a questionnaire asking developmental risk factors in the experiences and environments of participant children and families before service use was constructed. The questionnaire asked about known risk factors;

Focus child's birth-weight and gestational age,
Problems during pregnancy and/or birth,
Child's health,
Maternal physical and mental health,
Perceptions of social support,
Substance use during pregnancy,
Parental age at child's birth,
Number of children in family
Family structure,

Parental education,
Parental work status,
Child care used,
Family income.

This risk factor questionnaire was completed by participant families during the first data collection phase (Appendix F).

5.5. Participant Sample.

The following section will explain the participant criteria set for this study and will discuss the problems of including a control group before continuing to set out the process of recruitment and discuss some ethical dilemmas which were addressed during this phase of the study.

a. Participant criteria.

RCT Sure Start offer their services to families with young children (aged 0 - 4 years old) who live in RCT, therefore potential participant families had to be living in RCT and be about to use Sure Start services for the first time. Contact with such families was made by: generic health staff and staff in agencies associated with RCTSS who recruited families into RCTSS for the first time; Assisted Funding which allocated funding to families before term started: Researchers attending activities (baby massage, Next Steps, toy library) to recruit families who were using services for the first time.

To gain knowledge of participant families' environments, daily lives, and of children's developmental status before service use, and about their whole experience of Sure Start service use, it was necessary to collect data from families and children before, during and after service use. Families in which mothers used antenatal Sure Start services were therefore excluded from the study, as were families who had used services previously. This action was taken because factors which affect child development - such as maternal mental health during pregnancy, parental attitudes and behaviours (O'Connor, 2002) - may have previously have been affected or changed by Sure Start service use.

The age range of participants at the first data collection was set between 3 months and 4 years old. The lower age level aimed to avoid participant involvement during the earliest

few months of life when families are adjusting to a new baby, while the upper age limit of four years old ensured that all participants were eligible for Sure Start services.
To summarise, the criteria for potential participants were that they must be:

1. Resident in RCT
2. Aged between 3- 48 months at the time of the first data collection.
3. About to use Sure Start for the first time.

Families recruited to the study will be referred to as 'participant families', the child who services are aimed at or whose age made other family members eligible for Sure Start service use will be referred to as the 'focus child'.

b. Control group debate

This study is primarily qualitative, with a focus on the context, subjective experiences and perceptions of families who are using Sure Start, not on comparing the progression of children using services with those who are not. Control groups, if obtainable, would therefore have had limited use. Despite this, their use was carefully considered. Practical difficulties for a control group from RCT arose as all young children and families are eligible for Sure Start services. Similar areas of deprivation exist in Wales (Welsh Index of Multiple Deprivation 2001) but Sure Start is working in many of these areas and consultation with many of the Sure Start local programme co-ordinators discovered expansion to countywide services was already practiced or being considered. It was found that Cardiff Sure Start still operated in defined areas, and it may have been possible to draw a control group from their 'non Sure Start' areas, but this would have created a control group from highly populated, multi-racial urban areas, a group which could have significantly differed from a participant group living in the more rural, sometimes isolated, predominantly Welsh communities of Rhondda Cynon Taff. The need for developmental comparison in order to assess participant children's developmental status and progression in relation to their peers, was met by the use of the ASQ and ASQ:SE, which use generic measures to provide average age related developmental levels gained from the populations used to construct the developmental assessment tools.

> *'In this way generic controls, based on perceived normative standards, provide a benchmark against which the performance of treatment groups can be judged.'*
> *Clarke, A 1999, p.51.*

c. Recruitment

Consultation with service providers revealed that many referrals came from Health Visitors working in RCT. Service use was also initiated by other statutory bodies (e.g. preschool play groups, social services), by self referral and by use of drop in services. Ethical approval was obtained from the Local Research Ethics Committee of the Health Authorities providing services to RCT, and from Pontypridd & Rhondda and North Glamorgan NHS primary trusts, to allow generic health visitors to be approached and asked to assist in the recruitment phase. All the other services provided by or associated with RCT Sure Start were considered for inclusion in the study and some excluded due to the relatively small role of Sure Start in the funding of or provision of the services. The remaining service providers were approached to discuss the inclusion of their services in the study, and further services were subsequently excluded due to service provider's concerns about the sensitivities of service users, or because of confidentiality issues. All remaining services were included in the study (Table 5) and all staff agreed to help study recruitment by providing new service users with information about the study, and by obtaining contact details.

Table 5: Sure Start services involvement in present study

Recruiting services	**Excluded due to small role of RCTSS in service provision**	**Confidentiality/concern for clients/age clients**
SSHV	Books and babies	Safe start
SSCCW	Valley's kids	Dad's advisor
SSCSW	Rhondda Fach	Portage
Glyncoch family centre	PACT	Home Start
Penywaun family centre		Breast feeding advisor
Open doors		
Next steps		
SS counsellors		
Assisted places		
Talkabout		
Toy Library		
WPPA		

Shortly before the start of the recruitment phase, all staff and referral sources involved were re-visited, the purpose of the study was reiterated and information packs containing information sheets (Appendix G), and contact forms distributed. When contact details were received by the research team, the participant family was contacted by phone, the

purpose of the study discussed, the willingness to participate confirmed, informal consent obtained and an appointment made to visit the family home for data collection and formal consent.

d. Ethical issues

COREC approval for the study was sought and gained in October 2004. In addition, as mentioned above, ethical approval was also obtained from the Research and development offices of the Health Authorities providing services to RCT, i.e. from Pontypridd & Rhondda and North Glamorgan NHS primary trusts.

During meetings between researchers and the supervision team, two procedural policies were agreed.

1. The welfare of participant children:

The Sure Start programme is concerned with the health and well being of children. It was recognised that researchers may uncover signs of developmental delay or family problems that had not been identified or addressed. After discussion, it was agreed that any action made by the researcher to remedy or bring additional issues to the notice of professionals, agencies or other sources of help, would invalidate the research project, as it would prevent evaluation of the programme 'in situ'. The one qualification made was that if the researchers felt the child's safety was compromised at all, referral should be made to the appropriate authorities The welfare of the child was to be regarded as paramount as stated in The Children's Act 1989.

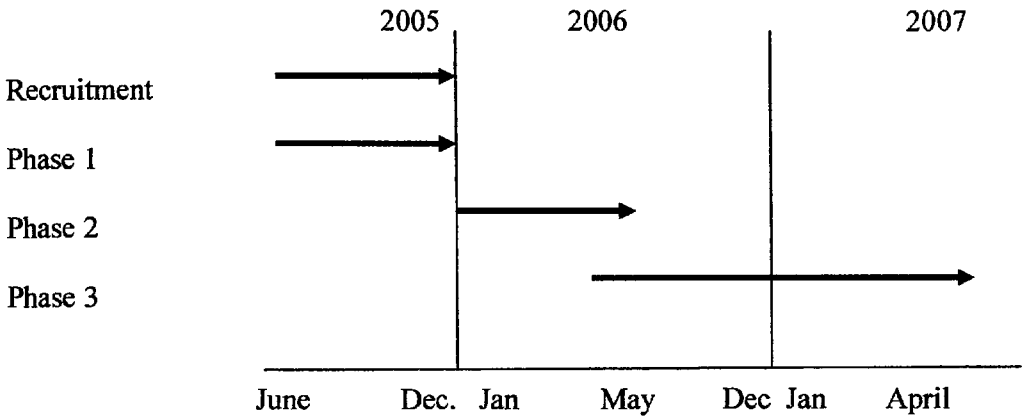
2. Researcher Safety:

To ensure safety during home visits it was decided the researcher should inform university staff immediately before setting out on the visit, should take a mobile phone to maintain or gain contact if needed, and should inform the staff when the visit was terminated. At the beginning of the home visit the participant family was asked whether they were happy for the interview to take place, and if the researcher felt threatened or uneasy the interview was to be terminated.

5.6. Data Collection.

The need to collect data from participant families over the whole experience of service contact and use i.e. before, during and after Sure Start service use, led to this project being designed as a short term longitudinal descriptive cohort study. Data collection was carried out over two years, in three successive phases, until participant children began school or until the data collection phase ended (Figure 9).

Figure 9. Data collection phases



The number of assessments for each participant varied depending on the services used and the age of the child. Those participants beginning school shortly after initial service use received two data collection phases, other participants were involved in all three stages of data collection.

a. Pilot studies:

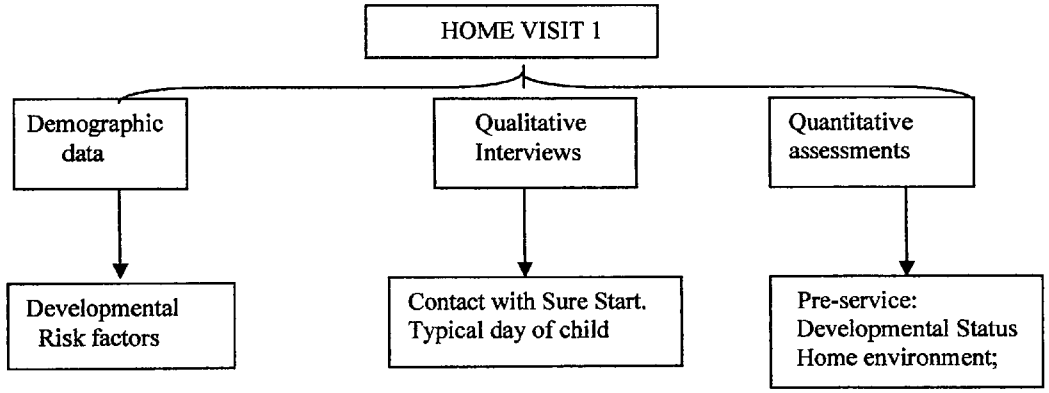
To enhance the reliability of the assessment procedures, the two researchers undertaking data collection familiarised themselves with the HOME assessment and completed the training scheme recommended and formulated by Cox *et al.* (2002) for use of the HOME assessment in Britain. The training was also used to compare inter-rater reliability, discrepancies were discussed and agreement reached about how to classify situations and observations until inter-rater agreement reached over 90%. The use of interviews to complete ASQ and ASQ;SE, HOME assessments, and generate narrative about the daily practices and routines of participant families and children was piloted by the researchers jointly interviewing and assessing three families living outside of RCT. No instances of families encountering or reporting difficulties in understanding or participating in the

assessment procedures were encountered. The data gained during pilot interviews were used to further check inter-rater reliability.

b. Data collection phase 1.

Participant families were visited at home. During this visit the study's purposes and involvement were discussed, consent forms completed, and consent to audiotape the visit obtained. Five participant families chose not to have the visit taped, and in those instances field notes and records were compiled. The first data collection phase consisted of the risk factor questionnaire, assessments of the child's development and developmental environment, and interviews about the child's typical day and how families came into contact with service use, (Figure 10).

Figure 10: Data Collection Phase 1:



To provide data about the existence of developmental risk factors which may affect the child's developmental level or progress, the risk factors questionnaire was completed. The ASQ, ASQ:SE assessments were then completed, with participant parents/carers given the option of completing them individually, or having the questions read out by the researcher. The HOME assessment record form was completed using researcher observation and from narrative generated by asking for a description of a typical day in the life of the child', and additional questions if necessary. Parents were then asked about the 'story' of how the families had come into contact with Sure Start services, how they felt about service use, and what their hopes and expectations of service use were. Parents were additionally asked about any particular needs they were aware of for their child , themselves or for their community (Appendix I). Throughout the visits, which took

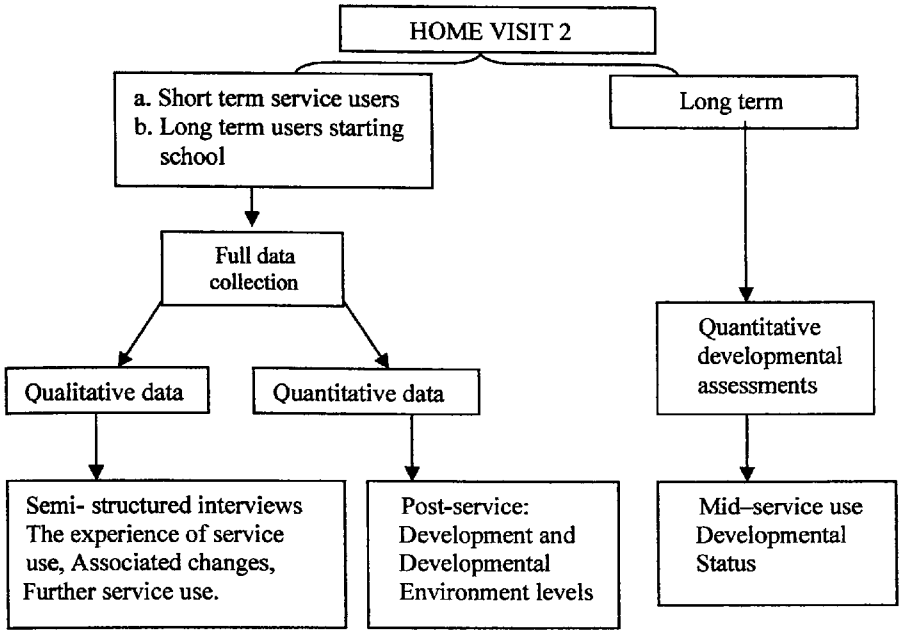
between one hour and ninety minutes, the interview was guided rather than directed by the questions as the aim was to enter the world of respondents, to understand individual families' lives and experiences, and give participants the chance to introduce issues the researcher had not thought of, as advocated by Smith (2003).

c. Data collection phase 2.

During Phase 1, a realisation grew that initial service use produced varying types of service interaction with participants, and this caused reflection on the best way to 'capture' the most informative data about the effects and experiences of service use, during the second data collection phase.

A significant percentage of participants were about to receive home based interventions to help parents address specific developmental or behavioural problems, or to meet other parental concerns. Although a developmental assessment 6 months later would have given data about the participant child's overall progress, if service provision was over a relatively short time, it was possible that any developmental progression achieved during service use may have decayed by the time of the next assessment. A further possibility was that parent's memory of their experiences and opinions of service use may have been affected between the time of service use and being asked for information about it. It was therefore decided that for those participants receiving a short term initial RCTSS service the second data collection should take place as soon as possible after initial service use ceased. Other participants, those using services, such as playgroups, mother and toddler groups, parental education classes, assisted places funding, were using services over extended periods of time and this use was likely to continue during the whole of or the majority of the study data collection phase, it was therefore decided to perform developmental assessments after six months of service use, and to follow this up with a full data collection when service use ceased. The timing of data collection and the type of information sought therefore varied between participants (Figure 11) .

Figure 11: Data collection in phase 2



Participants, who had received shorter term services (6 – 12 weeks) were visited within one month of finishing initial service use. A full data collection was carried out. This consisted of post-service child development and developmental environment assessments, and a semi structured interview which focused on the experience of service use, changes in the child and family environment during the time of service use, and whether parents associated these changes with service use. Families were also asked if they had been aware or used any further local activities or services since the last visit, particularly any further Sure Start services, (Appendix J). Some of these children were about to begin or had begun statutory education, so this was their last study visit.

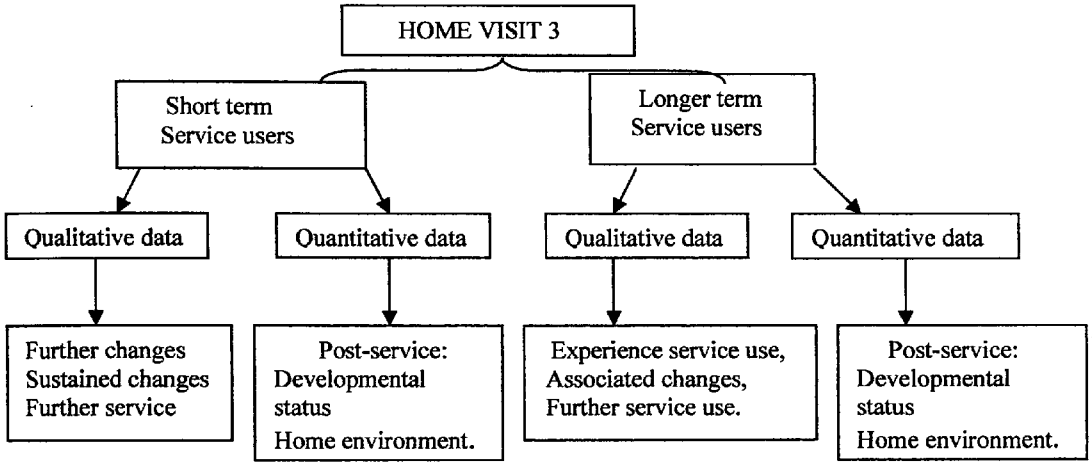
Participants using longer term services were contacted to fill in the developmental ASQ, ASQ:SE. A number of these children were about to finish long term service use to begin statutory education, these families were visited and received a full data collection.

d. Data collection phase 3

Phase 3 was conducted approximately 16 - 22 months after the first data collection phase. Data collection was carried out for some participants just before they began full time statutory education and for others, who had not begun school at the end of the data collection phase in April 2007, i.e. up to 22 months after recruitment began. Fifteen participants were still eligible for Sure Start service use at this time, but two of these

families had moved from the area and could not be contacted. A third data collection was therefore carried out for thirteen participants, seven of whom had been using long term services and six who had used shorter term ones. The final data phase collected full sets of quantitative and qualitative information (Figure 12),

Figure 12: Data collection phase 3



For participants who had been using long term services, the structure of the final data collection visit was identical to that of shorter term users in phase two. For users of short term services who had already received a full data collection in phase 2, the structure was similar but the interviews in the final phase asked about the endurance of initial changes associated with service use, rather than the experience of service use (see interview schedules in Appendix K).

5.7. Data Analysis

Analysis of the data gained during the successive home visits was aided by use of SPSS and NVivo. The following sections describe the processes followed:

a. Analysis of Quantitative data

SPSS was used to analyse data from the developmental risk factors questionnaire. Analysis consisted of descriptive analyses, the identification of participant families and children who were living with the number of risk factors that placed the focus child at increased risk of developmental probelms, and a Pearson correlation test to determine the strength of the association between two of the variables.

The ASQ questionnaire was used to assess the developmental areas of communication, problem solving, and fine and gross motor skills. Each domain contains six questions, and each reply produces a score (three point score: yes =10; not yet = 5; no =0). The total score in each domain (range 0 - 60) is then read in relation to a cut off point set two standard deviations below the mean value set during standardisation. This point was used to identify children with developmental delay in the separate areas. This information was then used to determine individual children's overall developmental states in the ASQ areas, before and after the service intervention or activity use. This information was entered into SPSS using a standard code, i.e. competent = 1, non competent = 2.

The ASQ: SE assessed the social and emotional development of participant children. The scores from the whole questionnaire were totalled and, as above, compared to a cut off line that indicates whether or not a child is showing developmental problems. Children's socio-emotional developmental state before and after the service intervention or activity, was entered into SPSS (competent = 1, non competent = 2).

The analysis consisted of: Analysis of the ASQ and ASQ:SE scores on an individual basis in order to identify the developmental state of each participant child during their contact with RCTSS (Appendix O); SPSS was used to produce Crosstab contingency tables of the developmental changes in focus children during their association with RCTSS; McNemar's test - a test able to analyse the significance of the differences identified between two correlated proportions (Lowry 2000) - was carried out to explore the statistical significance of the developmental changes identified by the Crosstabs test.

The quantitative HOME assessments that were carried out before association with RCTSS, gave overall HOME scores which consisted of six subsections or areas: responsitivity, acceptance, organisation, learning materials, involvement, variety. These scores were entered into SPSS. SPSS was used to conduct unpaired t tests to explore differences in the developmental environments of sample sub groups in contact with RCTSS.

b. Analysis of Qualitative data.

After data collection and full transcription of participant accounts, the data was entered into NVivo. Analysis of the interview narratives was divided into analysis of the pre-service developmental environment of participant children, and of family experiences of service use.

Analysis of pre-service developmental environment focused on the themes pre-determined by the six sub categories of HOME. The work of Bronfenbrenner was also consulted, with information about further factors that could influence the development of the child coded within the appropriate subcategory i.e.: the relationships of the focus child with family: the setting the child lived in; the wider settings (people, places, environments, contexts) the child experienced (Bronfenbrenner, 1979, p.21). This allowed identification of additional factors that may affect the child, but may not have been identified by sole use of the HOME interview.

Analysis led to participant categorisation in the following groups:

- Good developmental environment: Interviews gave evidence of stimulating developmental environment inside and outside of the house: parental involvement; routine in daily life; child centred activities; wider family/friends and community involvement
- Moderate developmental environment: Good/adequate developmental environment inside or outside of the house, but not in both
- Poor developmental environment: Poor environment inside and outside of the home, little parental involvement, little or no child stimulation, little outside contact or use of activities/facilities.

After the initial subjective categorisation which was carried out by the author, an additional researcher - who was familiar with and trained in the HOME assessment - carried out independent analyses of 50% of the participant narratives. Confidence in the reliability of the initial categorisation was enhanced by this procedure as complete researcher agreement was found in all of these narratives. Pearson's correlation test explored the relationship between the quantitative HOME scores and the subjective categorisation.

ii. The experience of Service use:

After full transcription of narratives about the experience of service use, NVivo was used to carry out a thematic analysis. The DSMEI predetermined the areas deemed important in the process of early intervention programme provision. Within these areas, this study's objectives were used to predetermine sub-themes and relevant narrative was identified and coded. Emerging themes were sought and sub-coded further:

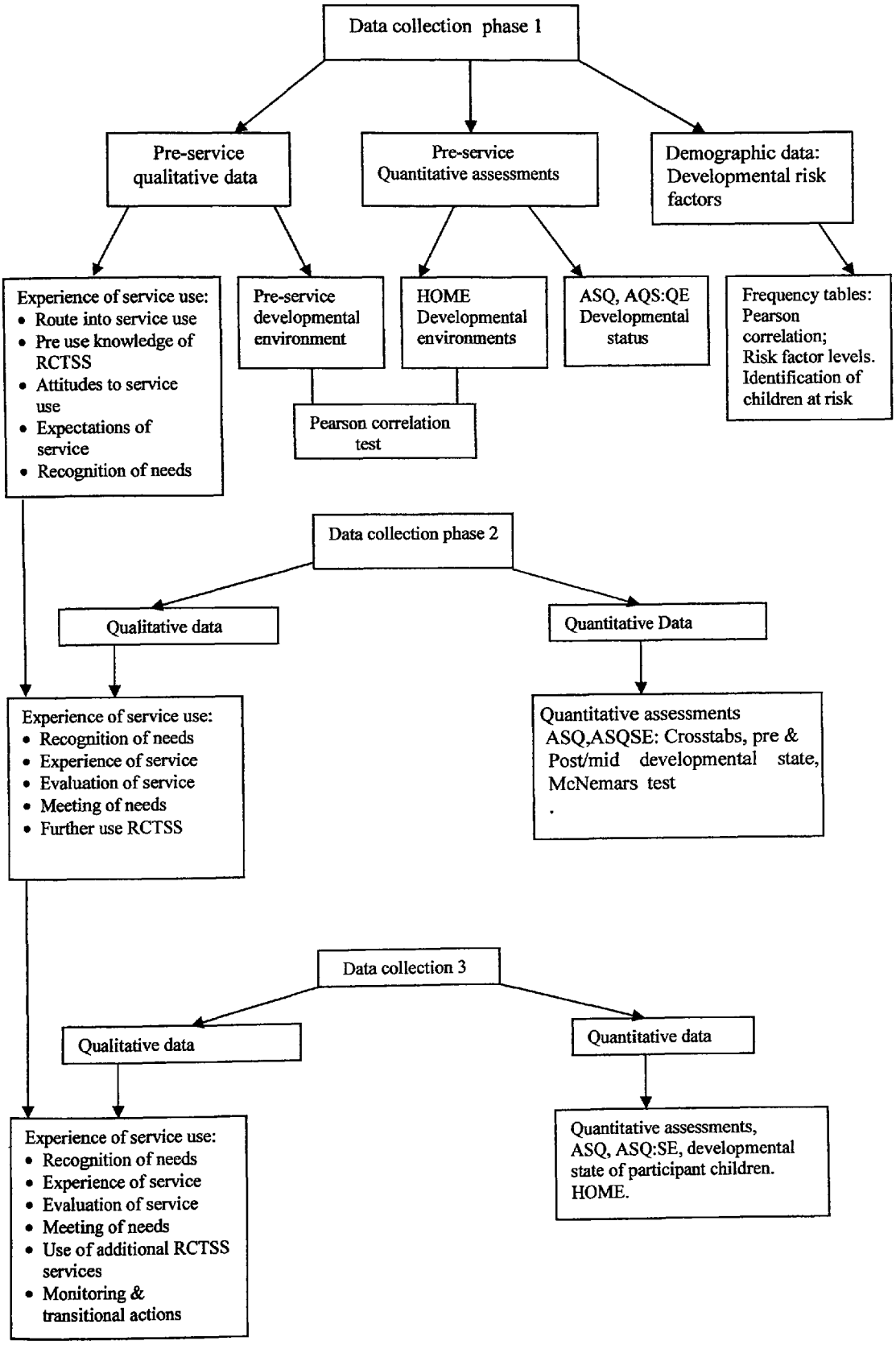
- The route or access into service use: This study sought to explore the reach of RCTSS, therefore themes were: the knowledge of RCTSS held by participant families before and at the time of initial services use; how service use began; the attitudes of families to their prospective service use; family expectations of service use.
- The assessment of children and families: Recognition of risk factors and/or of established developmental delays is important when providing early intervention services (Wolraich, 2005). The theme investigated was whether RCTSS service use included or led to recognition of participant children's developmental need(s) and risk factors. Narratives were therefore searched for evidence of some assessment or recognition of a child and/or family needs before and within the process of service use.
- The provision of services: Narrative accounts were studied to discover whether the services offered and used were able to meet all the identified needs of participant families and children. The additional interest in this area was whether initial service use led to additional use of RCTSS services and activities.
- Evaluation of service use: The study investigated parent perceptions of the effects of service use. Individual summaries were constructed from each individual account, as advised earlier (Appendix P). Gergen and Gergen's temporal model (p.110 -111) was then applied to the summaries to discover whether or not parents associated service use with any changes in their focus child's developmental progress and/or environment. An independent researcher applied Gergen and Gergen's model to ten of the twenty nine summaries and discrepancies were discussed and assessed to decide if further analysis was needed. Comparison of the analyses showed high levels of agreement, which suggested the authors's interpretation was reliable.

- Monitoring and transition into other services: As the needs, views and problems of participant families could change over their period of service use, the thematic analysis sought for evidence of some monitoring of the child/families situation, or of some recognition of changes that took place during service use.

Attention was given throughout to themes about different attitudes and feelings of participants. The aim being to identify events, emotions or situations which may impact on, affect or explain the experiences and/or perceived effects of service use.

Figure 13 sets out the stages of data collection, and the quantitative and qualitative analyses conducted at each stage.

Figure 13: Flow Chart of data collection and analysis



5.8. Conclusion

This chapter began by describing how the questions, objectives and aims of the present study arose. A consideration of qualitative and quantitative methodology then followed, a deliberation which led to the decision to use mixed methodology to best meet the study's aims. Narrative research was adopted as the main qualitative method in the study: narrative has the ability to explore the context and experiences of family participants before, during and after their association with Sure Start services from the perspective of the service users. It was then explained how use of quantitative data could strengthen the findings of this study by obtaining systematic data to warrant or challenge parental perceptions of any changes in the developmental progress of their children and/or in their developmental environments. The next section set out the criteria for participation eligibility in the study, how the associated RCT Sure Start projects were included or excluded from the study, and described the dilemma and reasoning which surrounded the decision to carry out the study without a control group. This was followed by discussion of the tools used for quantitative assessments, and the decision to use semi-structured interviews to generate narrative suitable for narrative analysis, but also to allow completion of the HOME assessment. The remainder of the chapter is more practical, it turns to a description of the recruitment procedure, the data collection phases, and of the data analysis. It also demonstrates how a deepening knowledge of the services, gained during the time of involvement in the research, led to some changes in the data collection phases. The final section describes data analysis. The next chapter presents the study's results.

CHAPTER SIX: Results

6. 1. Introduction

Data collection was carried out over three phases. The first two collection phases were carried out before and after or during initial Sure Start service use. Participants still using or eligible for Sure Start services over the whole time of the study took part in a third data collection phase. Table 6 summarises the three successive data collection phases, further details about data collection can be found in section 5:6.

Table 6: Data Collection phases

Home Visit	Service type	When	Demographic Assessment	Qualitative data	Quantitative data
1	All	Before service use	Developmental risk factors	First contact with Sure Start. Typical day in child's life.	Developmental status. Developmental environment.
2	Short term	End of 6 -12 week first service use		Service experience. Associated changes. Further service use. Other changes.	Developmental status Developmental environment
	Long term	Six months after starting service			Mid-service developmental status
3	Short term	Six-twelve months after finishing service use		Further service use. Sustained changes	Developmental status Developmental environment
	Long term	End of service use		Service experience. Associated changes, Further service use,	Developmental status Developmental environment

6.2. The study sample

Recruitment took place over six months. This relatively long phase was set to allow participants to be gained from as many services and areas of Rhonda Cynon Taff as possible. 36 potential participant families were referred to the researcher, of these two proved impossible to contact and three opted out after further discussion of the project. From an estimated RCT 0 – 4 years old child population of 13,885 (based on ONS 2001 census) a final purposive sample of 31 participant families was recruited – although as three families contained two children using RCTSS services this sample consisted of 34 focus children. Tables 7 and 8 show that the children in the study sample consisted of 21

boys and 13 girls aged between 3- 48 months old on first contact with RCTSS. Lack of a comprehensive RCT Sure Start data base prevented calculation of the number of new Sure Start users during the time of the study.

Table 7: Study participant gender

Gender	Number	Percent
male	21	61.8
female	13	38.2
Total	34	100.0

Table 8: Age of focus children on recruitment:

Age Bands (months)	Frequency	Percent
3 – 6	6	17.6
6 - 12	7	20.6
12 – 18	2	5.9
18 – 24	4	11.8
24 – 30	7	20.6
30 – 36	5	14.7
36 - 42	0	0.0
42 - 48	3	8.8
Total	34	100.0

This study is interested in whether RCTSS services are reaching the most disadvantaged families within RCT. With reference to the Welsh Index of Multiple deprivation (WIMD, 2005 revised), Table 9 shows the number of participant families living in areas of RCT categorised by the WIMD being one of the 10% of most deprived areas in RCT (Column 1, Appendix B).

Table 9: Participant area of residence.

Deprivation area	Families	focus children
10% most deprived areas	16	18
less deprived areas	15	16
Total	31	34

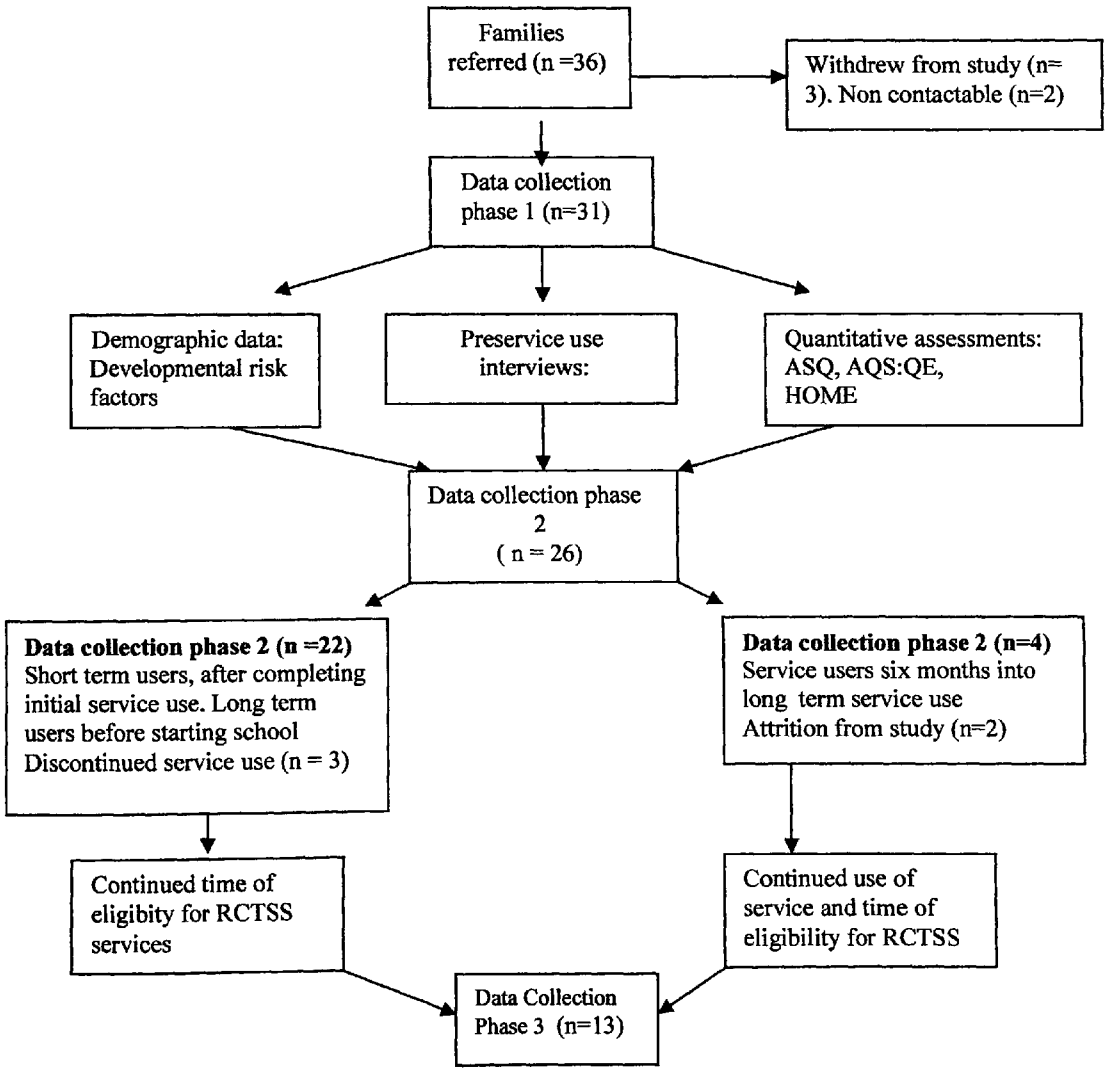
Participant families were about to use one of nine Sure Start services (Table 10). Referral back to information about Sure Start services (section 2:4.b) shows the services used by participant families represented 40% of available services. As discussed in section 5.5.c., the exclusion of some service users due to participant eligibility or service confidentiality issues excluded some services from this study. However, many core RCTSS services, i.e. SSCCW, SSHV, Toy Library, Talkabout, and SS Counsellors were represented within the study sample. Table 10 also shows that ten participant families (eleven focus children) used an initial service which was a longer term activity or resource, whilst for twenty-one families (twenty three focus children) the initial service was used for between six to twelve weeks.

Table 10: Service length and use of services by sample families N = 31

Service	**Service length**	**N (children)**		**%**
Short term				
Child-care workers	6-12 weeks	13	(13)	38.2
Health Visitor	6-12 weeks	3	(3)	8.8
Toy Library	6 weeks	3	(3)	8.8
Talkabout	6 weeks	2	(2)	5.9
Counsellor	6-12 weeks	2	(2)	5.9
Total		23	(23)	67.6
Long term services				
Next-Steps	preschool	1	(2)	5.9
Mother and toddler	preschool	3	(4)	11.8
Assisted places	up to 1 year preschool	2	(3)	8.8
Baby gym/massage	preschool	2		5.9
Total		8	(11)	32.4

31 participant families (34 focus children) took part in the first data collection. In phase two: twenty six families (twenty nine children) completed assessments; two families were impossible to contact; three families did not complete service use. Two families who dropped out of service use provided verbal feedback, but did not take part in full data collection, the other family took part in all data collections. By phase three, focus children's ages, allowed thirteen families to take part in a third data collection. This data collection resulted in longitudinal data for twenty nine focus children from twenty six families. The developmental contexts and the experiences of the families who failed to use services will be returned to later in this chapter, and in the discussion section.

Figure 14: Flow Chart of service use for participant families (n – 31)



6.3. Participant families' developmental contexts before service use.

To gain knowledge about the reach of RCTSS to disadvantaged families, information about the developmental contexts of focus children/participant families prior to service use was collected. Phase one collected data about the number of developmental risk factors focus children had or were experiencing before service use, and about their pre-service use developmental environments.

a. Developmental risk factors

Demographic and developmental risk factor data were collected by a risk questionnaire (Appendix F). The questionnaire asked about risk factors cited in the literature review (section 2.5), those identified by the questionnaire are shown in Table 11.

Table 11: Risk factors in participants:

Risk factor		N childen (families)	Percent
Birth weight	< 1500 grams	1	2.9
	normal birth weight	33 (30)	97.1
Gestational age	25-28 weeks	1	2.9
	32 - 37 weeks	2 (1)	5.9
	full gestation	31 (29)	91.2
Maternal age	20 years or younger	8 (7)	23.5
	Over 20 years	26 (24)	76.5
Post natal depression	No	20	58.8
	Current	9 (8)	26.5
	previously	5 (3)	14.7
Maternal education	fewer than 5 GCSE's	16 (15)	47.1
	5 or more GCSE's	18 (16)	52.9
Family structure	Single mother	7 (6)	20.6
Domestic violence	yes	3	8.8
	no	31 (28)	91.2
Low income	<60% average income	11 (9)	32.4
Social support	Good	23 (21)	67.6
	Not sure/poor	11 (10)	32.4
Smoking in pregnancy	never	25 (22)	73.5
	sometimes	3	8.8
	daily	6	17.6
Alcohol in pregnancy	never	21 (18)	61.8
	sometimes	11	32.4
	daily	2	5.9

The risk factors identified by the questionnaire were found to predominantly arise from the family unit rather than the individual child i.e. mostly family risk factors. The table demonstrated this as nearly half (47.1 %) of participant mothers had few educational qualifications. Two fifths (41.2 %) had experienced/were suffering from post-natal depression, and almost one quarter (23.6%) of mothers were aged 20 years or younger at the birth of their eldest child. Over one quarter (26.4%) of participants had smoked whilst pregnant with the focus child, with nearly one fifth (17.6%) using cigarettes daily. Two fifths (38.3%) drank alcohol while pregnant, with two mothers (5.9%) drinking daily. A fifth (20.6%) of participant families was headed by single lone mothers. One third (32.4%) of participants were living at or near the UK poverty line in 2005 (DWP 2005). One third of mothers (32.4 %) were not sure they had had enough social support or felt they had had poor social support since becoming a mother. Very low birth weight, very premature birth, and domestic violence were risk factors found in very few participants.

The range of risk factors identified amongst participant families was found to be 0-6, (mean 1.85). As discussed earlier (p.32) children living with four or more developmental risk factors have been found to be at greater risk of developmental delays. Approximately one quarter (24.5%), seven of participant families lived with four or more identified developmental risk factors; three quarters (75.5%) with three or fewer risk factors. Of the families categorised as living with few risker factors, 8 families (24.5%) gave evidence of living with none of the risk factors included in the study questionnaire.

Table 12: Participant families with developmental risk factors (N = 31)

Risk factors	N	**Percent**
Multi-risk (Four or more)	7	21.5
Lower-risk (One to three	16	54.0
No risk	8	24.5
Total	31	100.0

In the following sections which explore the experiences of focus participant children this categorisation will be used to refer to 'multi-risk' and 'lower-risk' families.

The majority of multi-risk participant families were living in areas of greatest deprivation within RCT (Table 13).

Table 13: Areas of residence for multi and lower-risk families (n = 31)

Risk factors	most deprived areas RCT	less deprived areas RCT	Total
multi-risk	6	1	7
lower-risk	3	8	24
no -risk	5	8	13
Total	14	17	31

A correlation test (Table 14) found that the relationship between risk status and living in areas in the quintile of greatest deprivation within RCT (Appendix B) was not significant. Thus living in more deprived areas was not associated with being a multi-risk family.

b. Participant's pre-service developmental environments.

i. Qualitative assessment of developmental environments.

Information about participant children's pre-service developmental environments was elicited by use of the HOME measure (Bradley & Caldwell, 1979). The semi-structured interviews, conducted as part of the HOME assessment, produced rich qualitative data about the lives of participant families and children. After full transcription, guidance given in the HOME assessment (Cox, 2002) and the ecological model of Bronfenbrenner (1979) were used to code developmental environments (see p.124). This led to participant categorisation as having good, moderate or poor developmental environments. as described in section 5.4.b.

Table 14 shows that approximately one quarter i.e. seven families (eight children) were categorised as having poor developmental environments: these accounts included little evidence of: child stimulation; parent responsiveness; parent/child interaction; community involvement. Two fifths (twelve families) of accounts described good developmental environments which included a comprehensive selection of home and community based developmental experiences with strong parental involvement and interaction. The remaining accounts (twelve families, fourteen children), described moderate developmental environments which included references to developmental experiences and/or encouragement in some areas but not others.

Table 14: participant families pre-service developmental environments

Developmental environment	N	Percent
Poor	7	21.5
Moderate	12	39.3
Good	12	39.3
Total	31	100

Representative summaries of each developmental environment are set out below:

i. Poor environments: The narrative summary below is representative of seven describing poor developmental environments. There is little evidence of stimulation in the home environment, and very limited community involvement with no child-centred activities.

Participant 32

In a typical day, C. wakes between eight and nine o'clock. He sleeps in his own room, and Mum doesn't know when he wakes, but goes in when she hears noises. She brings him downstairs, and gives him a bottle of milk, after which he likes to play with his toys on the floor. A little later he has his breakfast, he sits in his baby chair for this and gets excited when he sees his food. After breakfast he plays on the floor again, then Mum gets him dressed and in the morning he plays with his toys by himself. He likes to play with the buttons on the TV, and he likes watching television - particularly when he sits on his Dad's lap. At lunch time C. has a jar of baby food, and then has his nap. He sleeps for about three hours. After this he has another bottle and a nappy change. C. has a bath every other day before bed, he loves baths especially when he has bubbles, no toys are put in the bath. C. is then put to bed, he doesn't like stories and settles himself to sleep. Dad works long hours, often from 5.00 am - 8.00pm, therefore when he comes over for the night he doesn't want to do much more than change, have his supper and watch television. Twice a week Mum takes C. by train to go shopping in nearby towns. She isn't keen on the area they live in and does not use many facilities. She did try the mother and toddler once, but has decided not to continue. Mum doesn't see many friends now and some days she is bored. Dad takes them to the supermarket once a fortnight, otherwise Mum uses a couple of local shops. Mum would like somewhere else to bring him up, and to have some transport, she feels they live 'in the middle of nowhere,' but she feels that a move to another area is unlikely due to local authority housing availability, rent arrears, and because a violent ex-partner discovered the location of her last house.

ii. Moderate environments: Twelve narratives described moderate developmental environments. Some descriptions were of good developmental environments within the house, but little community engagement or activities. Others used stimulating, 'child centred' activities in the community but not at home.

Seven narratives were limited to good home developmental environments with little participation in the wider family or community.

Participant 31
In a typical day L wakes in her parent's bed, she has her own room but usually ends up sleeping with her parents. L. gets up with Mum and has breakfast with her brother. After breakfast Mum helps them both wash and get dressed. After her brother is collected by bus to attend his special school Mum takes L to school by car. After Mum has picked L up from school and both children are home after school, they have something to eat, watch television, play with their toys and look at their books. Mum spends time playing with them this time of day, and helping L. use the computer. The family do not appear to do much outside of the house, a couple of family outings to safari parks were mentioned, Mum said this was because L's brother - who has learning disabilities - likes animals. The children have a bath together and are read to or look at books in bed.

Five accounts of typical days included community based developmentally focused activities, but described little home based interaction or developmental input.

Participant 10
In a typical day H. wakes about 7 o'clock in his own bedroom, and comes into his parent's room. Dad takes him downstairs. In the mornings, after Dad goes to work, Mum makes sure he has his breakfast as he is a 'fussy' eater. He has his bath and then they go to a playgroup. This is a little way off as Mum does not know many people locally, but this group is closing soon and their intention is to go along to a nearer one with a friend then. If there is no play group, the morning may be spent at local toddler play activities, with friends, or - once a week - shopping in Cardiff. H. has a sleep after playgroup, and then eats his lunch by himself sitting in a chair in the sitting room. In the afternoon they may go for a walk, or H plays with his toys, usually by himself as he doesn't like sharing his toys. His toys are in his room, if he wants to play with his toys he plays in his room or visit his room to bring toys down. If Mum plays with him she does as he says or he has a tantrum. In the evening he eats his evening meal sitting in the chair, and spends some time with Dad before Dad gives him his evening bath and puts him to bed, he settles himself to sleep without a story.

iii. Good environments: Twelve accounts were found to be of days within which parents and children interacted and engaged in activities at home, and the child also spent time in outside activities and contacts which involved some child centred activities:

Participant 33
In a typical day J. gets up between six and six thirty every day, this wakes his brother. The whole family goes downstairs for half an hour together before going to get showered and dressed. The boys have their milk, and as J goes to nursery 4 days a week and has his breakfast and lunch at nursery, he often eats a piece of fruit or toast on the way. J loves it at nursery although he does have clingy moments, but he also has a nice group of friends. At one o'clock J is picked up by his paternal grandmother, who takes him home and does a lot of cutting, painting, and making things with him as she is relaxed about mess in her house. J usually stays at grandma's house until they go to pick his brother up at half past three. After this, they may go out e.g. go swimming, or go back to Grandma's or come back to their own house. Grandma gives them tea at 4.30p.m., she sits and eats with them and she always brings them back to the house before the parents come back. When Mum and Dad return they all have a quiet 'how did the day go' time. The boys have

their bath, and all go onto the parents bed to watch a little television, and have milk, then it is bed with a story by seven. At the weekends they may do the big shop, they visit beaches, the boys' cycle in the grounds they live in, and the family play together.

ii. Quantitative measures of developmental environment.

The HOME assessment gives an overall score which is sub-divided into different aspects of parenting and the child's environment and experiences. Table 15 gives the range and mean of the HOME scores for participant families placed in the pre-service use developmental environment categories:

Table 15: Pre-service HOME scores for participant families in different developmental environment categories (n=31):

Developmental environment	**N**	**Range**	**Mean**
Poor	7	16 – 27	22.6
Moderate	12	23 - 38	31.6
Good	12	33 - 44	40.30
Total	31		

The hypothesis that the qualitative categories would be positively associated with HOME assessment scores was confirmed by correlation tests (Appendix L). Higher total HOME assessment scores correlated with better qualitative categorisations, (Pearson's r = + 0.87). Further correlations explored the relationship of the different subscales of the HOME assessment with the qualitative categorisations, (Table 16):

Table 16: Intercorrelations of qualitative categorisations of developmental environments with HOME scores:

n = 29	**acceptance**	**response**	**organisation**	**learning organisation**	**involvement**	**variety**
Qualitative categorisation	0.38	0.81	0.47	0.69	0.76	0.72
Sig. (2-tailed)	0.032	0.001	0.007	0.001	0.001	0.001
n	29	29	29	29	29	29

Qualitative category:
Poor = 1, moderate = 2, good = 3.
* statistically significant at the 0.05 level, ** statistically significant at the 0.01 level.

This shows that better developmental environments as defined qualitatively, were positively related to higher scores in all the developmental sub-areas. It also extends knowledge about where the differences in the home environments of participants in the

different categories lie. The strongest relationships with the qualitative categorisations were found in the areas of parents' responsiveness to their child (0.81); involvement with their child (0.76) organisation of their child's learning environment (0.69), and the amount of variety in the child's day (0.72). The areas of acceptance (0.38) and organisation (0.47) showed significant but weaker relationships. To develop stronger understanding of participant's pre-service developmental contexts the next section links the pre-service developmental environments to the number of developmental risk factors.

c. Pre-service developmental context.

Table 17 links families' different developmental environments, with the number of developmental risk factors identified in the background data. It shows all multi-risk families gave accounts placing them in the poor developmental environment category, whilst lower-risk families provided either moderate or good developmental environments.

Table 17: Developmental environments and risk factors.

Type of environment	**Developmental risk factors**	**N (%)**
Poor	Multiple	7 (22.0)
	Low	0
Moderate	Multiple	0 (39.0)
	Low	12
Good	Multiple	0 (39.0)
	Low	12
Total		31 (100)

To explore the extent of the difference in the developmental environments of children in multi-risk and lower-risk families, a one way analysis (Appendix M) was performed with risk category as the between-subjects factor and areas of development as the contexts (Tables 18 & 19). It should be noted that these tests excluded two lower-risk participants because their age at recruitment (48 months) meant different home assessments had to be used.

Table 18: HOME subcategory means and standard deviations (SD) for multi and low risk participant's developmental environment.

Environmental area	Mean (SD)	Mean multi-risk	Mean low-risk
Acceptance	6.22 (1.12)	5.50 (1.60)	6.46 (0.83)
Responsitivity	7.50 (2.55)	4.64 (1.50)	8.46 (2.06)
Organisation	4.78 (1.21)	3.75 (1.03)	5.13 (1.08)
Learning organisation	6.75 (1.72)	5.00 (1.41)	7.33 (1.40)
Involvement	3.69 (2.12)	1.50 (1.41)	4.42 (1.79)
Variety	3.47 (1.30)	1.88 (0.84)	4.00 (0.93)

N = 29 . (higher scores indicate better environment).

Table 19: Differences in HOME environments of high and low risk families.

Developmental Factor	t	Sig. (2-tailed)
Acceptance (Unequal variances value)	-1.62	.143
Responsitivity (Unequal variances value)	-5.64	.001
Organisation	-3.23	.004
Learning organisation	-4.05	.001
Involvement	-4.71	.001
Variety	-5.77	.001

The results indicate that participant children in multi-risk families were living in significantly poorer developmental environments, (responsivity $p = 0.001$, learning organisation $p = 0.001$, involvement $p = 0.001$, variety $p = 0.001$, and organisation $p = 0.004$) than participant children living with lower developmental risk factors.

d. Summary

The pre-service results show that twenty four families (26 (76.5%)) focus participant children) lived with lower numbers of developmental risk factors in good or moderate developmental environments. They also indicate that seven families (eight children (24.5%)) of the focus children lived with higher numbers of developmental risk factors in significantly poorer environments. These children were living with four or more risk factors, i.e. the number of risk factors which places children at a higher risk of experiencing developmental delay (Sameroff *et al* 1987). The next section looks at the experiences of families during RCTSS service use.

6.4. Qualitative findings.

As explained in Chapter 5:4 narrative accounts of experiences of Sure Start services were obtained in a series of semi-structured interviews, and condensed into full accounts of each family's experience of service use. With aims of the present study in mind interest during analysis focused on:

1. Participant families' experiences of service use: Narrative accounts were used to explore participant families' experiences of service use. To ease this exploration and to facilitate comparisons, specific areas of service use areas deemed important in the Developmental Systems Model (Guralnick, 2001, 2005) were investigated. These areas were: how families came to use services; any assessment or appraisal of child and family situations and needs; the actual service use; service evaluation (see below); and a review of the family situation after service use.
2. Service evaluation focused on parental perceptions of the effects of service use. Gergen and Gergen's (1984) model (4:3.b.ii) was used to explore whether participant families associated service use with any positive developmental changes in the focus child's development or developmental environment.

Particular attention was given to parents feelings about the process and effects of service use. The main body of findings below were drawn from the narratives of all participant families, but a separate section considers the experiences of service use for multi-risk families.

a. First contact with services.

This explored how participant families came into contact with Sure Start services and identified themes which emerged about: the route/referral into service use; family attitudes to service use; family concerns before service use, and their knowledge and expectations before services use began.

Three themes emerged in relation to how participant families began using services.

a.i. 'Drop in' services

Nine families (eleven focus children) began using Sure Start services e.g. mother and toddler, toy library, baby massage, Next Steps, on a 'drop in' basis. The predominant

theme was that families had begun service use as not because of concerns for their child, but as part of their routine use of local community facilities/activities;

Participant 12. p.3 (Mother and toddler)
Researcher: So these days you're going to mother and toddler in the week ....when did you start was it last week?
Mother: Last week,
Researcher: Last week, and how did you find it?
Mother: Oh my family have used it..... I've always known it was there

Two mothers cited different motivation. Both families had had little involvement in their local community and started to use the activity to combat feelings that both they and their children were isolated:

Participant 5 & 6, p.1(Next steps)
Parent: So I never went anywhere, we stayed home. I never...mother and toddlers, two or three times because of the hassle of getting there.
Researcher: Yes yes.
Parent: My friend would try and help me , she lives down there and she did try and meet up and come down once a week to visit me with her daughter, her youngest is a week older than the boys.

When exploring parental expectations before beginning use of 'drop in' services, the general expectation was that service use would be good for the children, e.g:

Participant 13 p. 13(Mother & Toddler)
Participant: ..... we sent L to the group because we tried others round here and felt they weren't very organised.....though it was Sure Start down at ******.....you know the mothers seemed to be going for a bit of a gas with the children just rushing round ..not very organised. Anyway I knew this group near the school was good .....

When considering pre-service knowledge of Sure Start services many narratives, like the first quote above, suggested that most families using the 'drop in' services had good knowledge of and made regular use of local child centred facilities whether Sure Start or otherwise. It was this which had led to their use of the Sure Start services. However as exemplified by the narratives of participants 5 & 6 above, the two more isolated families knew of and used few local services before being made aware of their service.

ii. Families referred by staff from other agencies.

The narratives of the mothers of fifteen children showed that they were referred to services associated or provided by Sure Start to meet the concerns of health or educational professionals, rather than concerns of the parents:

Participant 31, p.16.(SSCCW & Counsellor)
Researcher: .....but you have your health visitor
Participant: Yes, and she is good
Researcher: And she recommended that you should have this Sure Start service, and she's going to come.....
Participant: Coming on the *** for an hour for seven weeks, starting then

Participant 29, p.10 (Talkabout)
Mother: ..... They must have looked at certain pupils and thought they could benefit more from it.

When looking at the attitudes of these parents the emerging themes varied: nine mothers were happy to receive the service:

Participant 28, p.10(SSCCW)
Mother: And I thought about it, and I thought yeh that'll be good

Although two of these narratives suggested that while the mothers themselves were happy to receive the service, different attitudes were held by other family members:

Participant 34, p.20 (SSCCW & Counsellor)
Researcher: Can you think why people may not want to take advantage of it?
Parent: My sister wouldn't
Researcher: Right
Parent : Ummm.....my mother and sister are strange and I'm not (laughs). No, well you were a bit horrified when I said about Sure Start (to her mum)
Grandma: Well I can't imagine that you would want someone to come and show you how to play with the kids, you would know....

In four narratives mothers appeared non committal about the incoming service:

Participant 21,p1(SSCCW, field notes)
.....he has also been referred to hospital by his GP because of concerns about his development especially his motor development. Mum says she is not sure there is a problem as it is only really since they recently moved to their new flat he has been in an environment where she has been able to let him sit and crawl and move around

Two mothers held negative attitudes and were not looking forward to service use:

Participant 32, p.2 (SSCCW, field notes)
She doesn't know what the Child Care worker will actually do but she intends to 'blank out' any stupid ideas the worker may have.

This variation in attitude may be related to the lack of knowledge about the incoming service amongst the families whose referral had been initiated by health and educational professionals. None of the families had been aware of the service beforehand, e.g.:

Participant 7, p.14. (SSCCW)
Researcher: would you have heard about it any other way?
Parent: I don't think so.
Researcher: Do you know about it?
Parent: No only from the leaflet they gave me yesterday.

Participant 28, p.10 (SSCCW)
Researcher: People don't seem to know about Sure Start generally, did you know about it?
Mother: No, I never heard of you.

Perhaps in accordance with this poor knowledge was the finding that expectations of the effect of service provision were more limited amongst families referred to services, e.g.:

Participant 4, p.11 (SSCCW)
Researcher: So coming back to Sure |Start what are you hoping they can do?
Mother: I don't think it's a problem.....but they can help him out 'cos they know what they are doing.

Participant 7, p.14(SSCCW)
Researcher: What do you think will happen?
Mother: She's coming for an hour.
Researcher: So you're hoping she can.....
Mother: Help.
Researcher: With.....
Mother: Mmmmmm
Researcher: Communication.....concentration?
Mother: Yes,yes, what's that smell? Oh nappy change.

iii. Self referral.

Eight families were referred to services after initiating discussions about family concerns with generic health visitors. The narratives of six of these families show that the referral was made to meet parental concerns about their children:

Participant 8, p.6(SSCCW)
Researcher: And how did you come to use Sure Start?
Parent: Well J is behaving so bad at the moment, so I said to * (Health Visitor) and she said would I like someone to come and help me with him
Researcher: Mmmm
Parent: So I said 'yeh' , tell me what to do like

Participant 10, p.1. (SSCCW, field notes)
Mum's concerns are that H. is unable to settle to anything, lacks concentration and she is worried he will find settling in and benefiting from his school education difficult, and anxious he may have an attention deficiency disorder. When Mum asked Health Visitor about this she was told about Sure Start,

The two other accounts showed that the main concern was the mother's emotional health, e.g:

Participant 3, p.9 (Counsellor)
Researcher: How did you decide to go?
Participant.: Well it wasn't me it was *** (C's father) I was so bad and he nagged me to go and in the end he said we have to do something so he rang the health visitor and asked for help. She suggested I go and see this counsellor.

The parental attitudes varied in degree i.e. all were positive, but the intensity of feeling varied. All parents appeared keen to use the service, but for some the incoming service was seen as vital:

Participant 33, p.12.(SSHV)
Mother: And privileged, we are really lucky to have them they are a pleasure to have they really are....it's just....I'm filling up because this help is the only thing that keeps us going.
Researcher: Ahhhhhhh
Dad: And we want to have fun with them, but it's just we are soooooo tired, and we can't have the fun

While others wanted reassurance:

Participant 19, p.19 (SSCCW)
Mother: Well I don't know if it will help or not but I suppose what I really want to know is if she can tell me if it is a real problem or.....
Researcher: A stage?
Mother: Mmmmmm, cos my mother thinks there is no need, but I don't know and I don't want her to get to five and the teacher says 'we have a problem', and then waiting lists.

Knowledge about the incoming service was again poor, i.e. no families knew about their service before referral was suggested, e.g:

Participant 18, p.10 (Assisted Places)
Researcher: So how did you find out about the assisted places?
Mother: Ummmm... well I didn't, I went down and I asked the leader, about her joining and she said yes she can join and it's £20 a week. . and then she asked about my income and I told her about the incapacity cos of my illnesses... and she said you could get subsidised , and gave me all the forms.

Participant 30, p.13(SSCCW & Counsellor)
Researcher:
You asked? for both?
Mother: Well I didn't know what was around, so I asked .... Yeh, well she said I could have either Home Start or Sure Start,...and I thought and I picked Sure Start, and I'm glad I did , because the SSCCW is so good.

The general expectation among families who asked for help was that it would have some positive impact for the child and/or families, e.g.:

Participant 22, p.7 (SSHV)
Researcher: What are hoping the service will do for you?
Mother: To get him sleeping in his bedroom at nights, that's it, if we could do this it would have such an impact on the family because I'm so tired all the time, and me and my husband never get five minutes to ourselves...and we need some time for M (their other child) on her own. I think her behaviour will improve.

iv. Summary.

In summary, the themes drawn from family accounts of how began service use were:

- Families came to use services in one of three ways,
  i. Use of 'Drop in' services.
  ii. After being referred because health or educational professionals were concerned.
  iii. When families approached health staff about concerns for a family member.
- Attitudes to service use varied. Most parents using 'drop in' services expected service use would benefit their children. Exceptions to this were found in accounts from two families who used 'drop in' services to combat isolation, these mothers felt that they would benefit as well as their children as it would get them out of the house. Variation was also found in the attitudes of families referred to services by educational or health professionals: two mothers held negative feelings, four were non-committal (don't mind), while nine held positive attitudes. When analysing the narratives of the eight families who had asked for help, the overriding theme was that the families felt positive about service use and were keen to begin working with RCTSS,
- Expectations also varied. Much variation appeared related to the reasons for initial service use: Most mothers who used 'drop in' services felt it would be good for their child and help them develop – but also felt their children were developing well without the service and so did not place any particular emphasis or expectation on the new activity. Exceptions were the two mothers who were

isolated, as stated they hoped the service would provide them with some occupation and socialisation. Within the families who were referred to services, seven mothers felt it must help their child; six said that they didn't know what would happen or that it could do no harm, whilst two mothers implied service use would be unwelcome or intrusive. Of the eight families who had asked for help all were keen to have the service and had great expectations about the help it may give.

- One recurrent theme was the general lack of knowledge held about RCTSS services. Although many families had heard of Sure Start, knowledge about the individual services and activities was poor. Even amongst the families using 'drop in' services, many of whom had good knowledge of local activities, only one mother - whose child attended the mother and toddler group - knew it was a Sure Start group before she enrolled her child. The rest in the 'drop in' group viewed their service as part of local activities or accessed it when the Sure Start Toy Library visited their local playgroup. None of the other participant families i.e. those who been referred to RCTSS, either by request or to meet the concerns of professionals, had known of their service beforehand.

b. Assessment.

No assessment occurred for families who used the 'drop in' services. Narrative accounts from families referred due to professional concern that suggested single members of staff i.e. the generic health visitor, play group leader or reception class teacher initiated these referrals. Where families had asked for help, Appraisal of family needs appears to have been carried out by the family themselves and their concern confirmed by the generic health visitor who organised the referral. Questions during the first interview before service use included

> *'Have you ever been asked what your needs are for your child, for you as an individual, a parent or as part of the community'*

The majority of narratives suggested that most mothers felt they had never been asked about their needs, e.g.:

Participant 1, p.9(SSCCW)
Researcher: Has anybody asked you what your needs are? You know for the baby but also what about you, has any body asked what your needs are what would be good for you, yourself or your community?

Participant: No
Researcher: No, Not your doctors or midwives or health visitors?
Participant: No

Participant 4, p.11 (SSCCW)
Researcher: Ok Umm....has anyone ever asked you since you had .....or..... what your needs are for L.....or as an individual , as a parent?
Participant: What do you mean by needs
Researcher: Things to help, go..
Participant: No not really.....it's all here like.....
Researcher: But no one's ever said is there anything that would help?
Participant: No not really.....I mean the health visitor with this speech thing now
Researcher: Is the first ok.....

Participant 12, p.8 (Mother & toddler)
Researcher; Has anyone ever asked you,- your Health Visitor or any one- if there is any thing you need or would help, basically is there anything you need as a parent, a individual or even in your community that would help.
Participant: Umm, no, no never.

Participant 20, p.16 (SSHV)
Researcher: Lovely....has anyone ever asked you what your needs are for the children, as a parent, an individual what would help?
Mother; Umm...no

However, five accounts did suggest that this experience was not universal, the families had close relationships with their generic health visitors, who had suggested or tried various avenues for help, e.g.:

Participant 29, p.22 (Talkabout)
Researcher: Yes, and you know them well they are yours. So has anyone every ever asked you about your needs as an individual?
Mother: no
Researcher: As a parent?
Mother; Umm.....I suppose the Health Visitor, she is brilliant

Summary

There appeared to be no comprehensive assessment on referral into service use, although generic professionals referring to SSHV's and SSCCW's filled in short referral forms. Neither was there any evidence of assessment of the child and families wider needs once work with RCTSS began.

c. Service use.

Narrative analysis centred on the experience of service use. Interest was in how well families had engaged in service use; what their feelings about service use were; and

whether the initial service had been the first step into further use of RTSS services. Since the attitudes and expectations of participant families were found to vary with the way they came into service use, the following section is divided into themes found within these categories.

i 'Drop in' service use.

One theme drawn from families who used 'drop in' services was that all participants appeared to enjoy the service/activity,

Participant 12,p.6 (Mother & Toddler)
Researcher: .....so to go back to mother and toddler can you tell me about that when she started.
Participant: Well .....I suppose .....it was for her, it's the other children, she really loves being with others, and going there.....well she got to see others, learning how to get along.....she loved it.....and of course lots of them have gone to play group and will go to school now in September, so they can all go together

Participants 5& 6,p.18 (Next Steps)
Researcher: So overall how would you describe your experience of Sure Start services?
Participant : Mmmmm right, Oh fantastic

The parents and children seemed to use the service regularly and become engaged in the sessions

Participant 12,p.14 (Mother & Toddler)
Researcher: So you'll carry on for how long ...with mother and toddler?
Participant: Like I said we still go now but not as much because of 'Growing together' but I suppose we'll go now 'til the summer.

Participants 5& 6,p.19 (Next Steps)
...its been two years now. I got....well you'd say I spend a lot of money if you saw my craft cupboard upstairs, I make cards for friends and things ...and the boys have access to things like the stamping machines and I think they are more creative...

Mothers describe services in a way that suggests they felt the activity had been of good quality:

Participant 12, p.14 (Mother & Toddler)
Researcher: and how do you feel about mother and toddler....looking back?
Participant: Oh it's good, I've always known about it.....you know they do lots of stuff and it kind of leads into the group as places come up.
Researcher: Yes, so like a continuation, mmm.....

When asked about use of further Sure Start activities/services. The theme from families using Next Steps, Mother and Toddler, and those who had used the Toy Library when it visited their playgroup, was that they used further services which arose from their original one, whether they were Sure Start or not.

Participant 25,p.10 (Toy library)
Researcher: ....I suppose the toy library has finished now?
Parent: Yes, it went on for a bit, but we still go up to the group on Fridays and there's a different thing there, but I don't know if it is Sure Start ..... Mmmmmm..... it's, well you know, it's doing stuff, he does cutting and pasting. He likes cutting, with scissors, we made a book, didn't we ? We made a book, what was in it?

Participant 13, p.13(Mother and toddler)

Participant: Well yes, of course you know she doesn't go now.....
(later) in the end, because Nana was there I felt, and Mum felt too, that L was becoming a bit dependent on her, you know, going to Nana too much not learning to be a bit more independent. So then L got old enough and a place came up at play group...
Researcher: Mmmhmm, And where was that?
Participant: No, no it's the kind of extension when they get old enough at the same place.....she started there in September, and she goes by herself so that's good for her, and for me cos it's in the afternoon which means sometimes I can go and pick her up and get some contact with the staff.

Of the two families who had felt isolated before service use, one family had become more involved in the original Sure Start service and had increased use:

Participants 5 & 6, p11 (Next steps)
Researcher: Are you still going to Next Steps?
Participant : Oh yes we go five times week, now
Researcher: To Next Steps?
Participant; yeh, there are loads ...there are 3 or 4 fulltime tutors ...Monday I go to Y**, the new one started in my local church.

However the other family's account suggested that service use had changed little in their situation, they had ceased use of the original service, appeared to still be isolated, and were using no additional Sure Start or local services at the time of the final visit:

Participant 15,p.12 (baby massage)
Researcher: And did you just remember it ?.....or did you....how do you find out about local things? Activities and stuff?
Participant: Well at work, when someone, a lady who was leaving, we were walking together .... was saying .....I was saying I was in the house with my baby and she was saying why don't you take her to the playgroup...and I was saying ..... oh I don't know about it, I don't go out much.
Researcher: is that a problem finding out what is going on round here?

Participant: ...I....actually.....I don't know what is going on round here much

ii. Service use due to professional concern.

Themes arising from the families referred to meet the concerns of health and educational professionals varied. Three participant families – all of whom had held non-committal or negative attitudes to the service before use – dropped out of the SSCCW service early on. These families were all multi-risk and the details about lack of service use can be found in the multi-risk section later.

When considering whether the service use had been enjoyable, among the families who remained in service use, five appeared to enjoy the service, e.g.:

Participant 4, p.18. (SSCCW)
Parent: Yes, she explained about playing, yes...
Researcher: So were you surprised? What went on
Parent: I thought it was really good, I dunno what I expected, but I thought it was really good for L., he used to love it, used to be excited, didn't you boy?

These families completed service use and engaged well in the sessions, e.g.:

Participant 29,p.13 (fieldnotes, Talkabout)
M thought it was 'fab' Mum being in school, he really enjoyed it. Someone came round and chatted went round and made sure all had everything needed and to chat, see how people were getting on. Mum enjoyed this too. Mum felt she benefited from seeing M was more confident than she thought, and seeing the little 'wobblies' he had when he won't share. She liked having things to bring home and so they could look at it again and say we made this together. .....

All these parents felt the service they had received had been of good quality,

Participant 29,p.11 (fieldnotes, Talkabout)
(later) Mum would say the service as 'brilliant without a doubt.....

This feeling of enjoyment was not evident in all the narratives of referred families. Three had appeared to find service use difficult, e.g.

Participant 34, p.28.(SSCCW & Counsellor)
Grandma: Does A know about the counsellor in Sure Start because you didn't like that? That was terrible.
Participant: Yes, but that probably wasn't her fault it was probably me you got to be the right kind of person.
Researcher: Yes but we are interested in your experience of that J, because that is important. It doesn't sound as if it was for you.
Participant: No it wasn't, it was awful.

Despite the difficulties of using services, two of these families engaged in and maintained service use, and after service use they agreed with other mothers in this category that the service had been of good quality. The mother who had disliked the counselling service stopped attending. Her generic health visitor referred to a community health worker which was more successful.

The narratives of the remaining families in this category strongly suggested that they had not really enjoyed service use, e.g.

Participant,7 p.17 (SSCCW)
Parent: C had to complete the task before she would show something else. With C it can be hit and miss, she's not talking, she says 'yeh', so she listens and concentrates, and sometimes she gets fed up. And some times I think it was so awkward having the SSCCW coming here cos I, she would come about 4, 4 o'clock, and I was just home from work, and C hadn't seen me all day and sometimes she would work for the SSCCW, and sometimes she wouldn't.

There was little evidence that these parents had become engaged in the service themselves, it appeared they believed the service was only for the child.

Participant 21, p.3.(SSCCW, fieldnotes)
The sessions include the worker coming with toys, L likes it when she comes and she has been playing fine motor skills games and teaching him body names. Mum feels this has had an effect as he is playing more. Mum sits and watches, she does not get down and join in, and feels that the sessions are for him to play not for her.

Although this mother had felt the service had been of good quality, the other mothers appeared less convinced, e.g: one mother felt she had receivied the wrong service:

Participant 28, p.14 (SSCCW)
Researcher: So who came?
Participant: a lady called R
Researcher: R, right
Participant: she came for about 8 weeks
Researcher: Right and what did she do?
Participant: she sat and played games, lots of different toys, different every week. Really nice lady I thought she was fantastic, but on the other hand. Don't get me wrong, she was great, M. loved her, waiting in the window for her. ...but it wasn't what I thought it would be.

Initial service use led to little referral to or use of other Sure Start services. Mothers in this category referred to barriers which were also mentioned by families using services after asking for help, therefore this subject is returned to below.

iii. Service use after help had been requested by families.

All the eight families in this category had fully used their service. Six families had felt that the service had been enjoyable, e.g.:

Participant 8, p.15(SSCCW)
Parent: It was usually Thursday on 'bout half past nine , or ten o'clock
Researcher: mmm...and what did she do when she came
Researcher: And while she was doing this was she playing and talking to him
Parent: Yeh
Researcher: And would you say he enjoyed it,
Parent: Yeh, He looked forward to her coming

In most families it appears that most mothers and children engaged well in the service they were using, e.g:

Participant 3,p.14(SSCCW &Counsellor)
Parent: Well I've had a lady come here, and to be honest like she told me, I've gone through a lot of changes at the moment, and she's supported me through it, and cos they teach us about parenting, she didn't really teach me anything, because M is like coming on, and um, she's just there to talk to me and see how she is developing, and she isn't really here for that long, but she's doing so well. We are just chatting about general things

This theme could not be found in all narratives. Two mothers did not appear to become very engaged in the service themselves. One mother felt it was provided only for her son:

Participant 8,p.16(SSCCW)
Researcher: right, did she involve you as well or was it just her and J.?
Parent: Just her and J, well she did talk to me, but she played with him and that, try and engage him, see how advanced he was.

Whilst another family had little contact with the SSHV:

Participant 20, p.16 (SSHV)
Researcher: the SSHV, and did she come to the house or the school?
Parent: She came here, basically once or twice and then the generic Health Visitor took over
Researcher: Right, and what did she do
Parent: She did, we had to fill in forms, then she came and watched him eat...which takes about 2 hours, so she didn't stay till he finished!(Laugh), and then she handed over to the Health Visitor who said try him on these foods, do this, only give him half an hour to eat, time him if longer he goes about, you got to give him afters, a choice of things, have breakfast, dinner, tea and supper, just like a new programme, new diet try things
(later)
Parent: Well I don't think it worked at all, cos .....he takes longer on his tea , cos he knows he's only got half an hour so if he don't want it, he just takes longer and it goes in the bin, so I don't think it did, but we stuck to the plan .....we just stopped it now.
Dad: Well I think if we carried it on, it might, as he was trying a few things he hadn't before

Mum: Yeh he didn't much, all he tried was tea bread,
Dad: And peas, and he likes Worcester sauce which he hadn't tried before

Most parents who had requested help appeared to think that the service had been of good quality

Participant 19, p.13 (SSCCW)
Researcher: So when she came what did she do?
Parent: When she came she brought these activities, for example, one week she brought a house, another week a kitchen and they played and another thing was colouring and she played and she talked to her as she played with her and she was asking certain words, that H.couldn't pronounce, 'cos she would talk to you, you know she would rabbit on but it was the pronunciation of the words, so I told the SSCCW some of the words, for example if she was talking about her house, she would say are you coming to my 'waff', and SSCCW had a word with a speech therapist, and they said it wasn't common, it was something she had picked up from somewhere, and then she brought the activities that centred on the word, like in this one the little girl playing and she kept bringing up the word 'house'.

Participant 10, p.6.(SSCCW)
Researcher: So what did she do?
Parent: She brought and played with toys, books, she would move him on if he was getting bored, new things at that. Cos I thought I was doing something wrong or he had ACHD or something because when he gets fed up with something he can be mad, but she said ' no' he would never be able to concentrate if.....she said it was normal, now and again if he were bored to ..... well we did maths a... matching and stuff and only once we were talking about it and he just said he didn't want to play with that. And when he said that you know he was listening.

When considering further use of other Sure Start services for families referred or who had asked for help, a little further service use was evident.. For two families this was the result of information provided by a RCTSS staff member e.g:

Participant 28,p.17 (SSCCW)
Researcher: Right, well I can see that the service was interesting, but did she talk to you much about managing behaviour in the sense you wanted?
Participant: Well no, but if I had a question she was always suggesting there were other people out there who could help, like umm M. went through a stage where he wouldn't go to bed for me, so she suggested another SSHV who came, and she was marvellous and she gave me a programme and told me what to do if he came out, and she said follow this and he'll be in bed by the end of the week and I did and he was, and he hasn't been out of his bed since.

Whilst two other participant families found further services and/or activities through friends or in the community, e.g:

Participant 10,p.12 (SSCCW)
Researcher: Did the SSCCW recommend anything else for you to go to?

Parent: Umm, my friend goes to Tumble Tots in Abercynon and I have taken him to that,

Participant 34., p.20 (SSCCW & Counsellor)
Participant: there was this thing the other week at the library, Sure Start they were doing stories or something and starting a language thing, and I arranged for my mother in law to take her cos I was in work.....and we had terrible snow and we didn't go!

When asked what prevented further service use the following themes were identified as barriers.

- Lack of knowledge, e.g:

  Participant 3,4 p.20 (SSCCW & Counsellor)
  Participant: We just went in the library and this lady said about it...nothing...much
  Researcher: Ahh, I was going to ask you about how you found out about things because there is quite a lot going on ..... near and far
  Participant: You don't get anything, no. Nothing

  Participant 19,p.20 (SSCCW)
  Parent: When I said to my friend who has a little boy the same age do you want to come, and she came, we walked through the town there was nothing advertising it, nothing outside the uni
  Researcher: Nothing to say you were in the right place
  Parent: Nothing, and it wasn't in the Observer, and she said you've got the wrong day, and I thought I probably have, knowing me like innit, but we went in and it was there and I said to the SSCCW, you should advertise it more, but she said (parent speaking very quietly now) their boss said we can't advertise it because of paedophiles and they will hang round to see the children, they'd hang round...they were only able to advertise it in doctors services and Health Visitors could tell people.....So if I hadn't been working with Sure Start for H, I wouldn't have known, no one would have told me, which is a shame, that's the only down side, if she'd been a first child I'd not be in touch with Sure Start and know about anything of the nice things they're doing.

- Transport problems, e.g:

  Participant 10, p.13 (SSCCW)
  Researcher: Did the SSCCW recommend anything else for you to go to?
  Parent: Umm, my friend goes to Tumble Tots in Abercynon and I have taken him to that, but as I don't drive and I have to take the train, with the weather and that, its awful, so I haven't gone to that more, it's got to be something quite close, quite local.

  Participants 5 & 6,p.18 (Next steps)
  Researcher: So.... you haven't heard of any other services since we last met?
  Parent: Without the car it is so difficult
  Researcher: Transport is a big issue?

Parent: It is, I mean here as well, the thing is with weather as it, just to get to the community services in the hall it is a long walk and they're just not used to it.

- Parental attitude.

  One family did not use further services they knew about because attendance was viewed as too much trouble:

  Participant 23 & 24, p.18 (Assisted places)
  (later)
  Parent: Mm, well I heard of toy library
  Researcher: Right, and did you use it
  Parent : No.....well you know , it is the hassle of taking them both up there in the buggy, and well....I just didn't.

- Parental working hours.

  One mother said work hours and responsibilities prevented further service use:

  Participant 7,p.13(SSCCW)
  Parent: We went to a reading at the school and there was something on Sure Start, and who was it?
  Researcher: Oh I know ...
  Parent: Mmmmmm...and a talk on how and why you should help your child get ready for school or something and I said it would be better for me in the evening, and we got a letter from the school and it was all in school hours, and I could take time off, but it's my class as well, and the women I work with.

- Money and age

  One parent cited age, financial concerns, and lack of awareness as reasons for non-use, i.e.

  Participant 17,p.7(Counsellor, field notes)
  Mum has not heard of any other services for new mothers apart from ones targeted at teenage mothers for which she is too old. When asked about other SS services, mum first said she had not heard of others but when directly asked she had vaguely heard about the toy library but didn't know where or when she could access it, and had been told about the baby gym (thinks something came through her door) but said she didn't know if it cost and sometimes just finding 50p was too much for her. Most of her knowledge of local services came from reading signs and posters.

iv. Summary.

Interest was in feelings about service use; how well families had engaged in service use; and whether the initial service had been the first step into further use of RTSS services.

- A strong theme was that service use had been enjoyable. Of the families who had fully used the services, the majority found service use enjoyable to some extent.

Exceptions consisted of families where services were addressing children's eating and sleeping behaviours, and the two mothers seeing the SS Counsellor. It is of note that two other mothers whose accounts suggested that they had not enjoyed the SSCCW service had held a non-committal attitude to their initial referral. In additional, the mothers in three families who quickly dropped out of service use had held non –committal or negative attitudes from the outset.

- Quality of service: most participant families felt the service had been of good quality. The exceptions consist of: the family seeing a SSHV about the child's eating problem who only saw the Sure Start worker twice and said little about their contact; one mother who felt the timing of the visits impacted badly on the concentration of her daughter; one mother felt the service was good but was not what the family had needed or expected; and a family who thought the SSCCW wonderful but found seeing the Counsellor a bad experience as the approach did not suit the mother
- Engaging in service use: Of those who completed service use most families fully engaged in it. Two mothers using SSCCW said they did not get involved as the service was for the child. The family with the child with eating problems only received two visits from the SSHV. The mother who did not like the SS Counsellor withdrew from use but carried on with SSCCW
- Analysis strongly suggests that use of or referral to one RCTSS service did not act as an introduction to the rest of the available Sure Start services for the majority of the participant families. Barriers to service use expressed by participants were:

    i. Lack of knowledge of services
    ii. Transport problems
    iii. Hours of services
    iv. Disinclination to use services
    v. Age: two parents felt services were for teenage mothers
    vi. Finance

d. Service evaluation.

The interest was in any changes in participant children and/or in their developmental environments since service use began and whether parents felt these changes were associated with service use. Gergen and Gergen's model (1984) was applied to summaries of participant narratives (Appendix P) to discover whether families associated service use with any positive developmental changes. Analysis placed focus children in the categories identified by Gergen and Gergen : stable; progressive; regressive (p.107):

- Eight (31%) parents of nine participant children felt service use had not changed the child or his/her developmental environment, all these were categorised as having stable narrative structures
- Fourteen (55%) families talked of positive changes in sixteen children, and/or in their developmental environments, or in both. All parents associated these changes with service use to some degree. These were classed as progressive structures
- Four (14%) participant families found the service had not had any sustained impact, and the child's development and/or environment had deteriorated during or shortly after the time of service use. These were classed regressive structures
- Five (17%) families did not take part fully in the data collection and /or the service, these were termed incomplete narratives

The following section presents representative parts of the narrative summaries which describe the perceived effects/outcomes of service use.

i. Stable narratives:

The narratives of eight families had stable structures. Five accounts – four from families using 'drop in' services and one from a family whose child had been referred to 'Talkabout,' described good child development and developmental environments before and after service use, these narratives were therefore sub-classified as satisfactory stable narratives. Three accounts from families, two using services they had asked for to meet concerns about their child (SSHV, SSCCW) and one using a 'drop in' service to combat isolation, referred to ongoing poor child development and/or developmental environments before and after service use, these were sub-classified unsatisfactory stable narratives

Satisfactory stable narratives showed that the parents thought the services were good and the children had benefited, but that service use had made no real difference, e.g.

Participants 27 & 28 (toy library)
Mum feels the children have many toys and things at home and she spends a lot of time playing with the children and helping them develop, so the service made no difference to their progress.

Unsatisfactory stable narratives suggested concerns about the children's development/environment were unalleviated by service use, i.e. parents associated no changes in their child's developmental progress or developmental environment with service use. Two families had requested help and received home visits from a SSHV and a SSCCW. One family had used the baby massage 'drop in'. The theme was that nothing much had changed:

Participant 8 (SSCCW)
Mum could not think of any changes that had occurred in J, during the time of the sessions, but commented his speech had improved recently. He is not biting now, but he is swearing more and his violent behaviour (hitting) remains. Mum felt she had not learnt anything from the sessions, and her experience of the service had not led to any changes in J.'s day, or in her interaction with him. Advice about potty training was given and that had been very useful, Mum said the worker would be welcome any time.
Six months later Mum says she is finding life easier at the moment, she is in a new relationship and pregnant. However, Mum is very concerned about the increasingly bad behaviour of her eldest son, she thinks he resents her new relationship. Nothing much has changed for J., his days are much the same although he begins school soon. He does not bite so much now but still swears and kicks a lot. No other activities have been found or suggested by anyone. Mum says she sometimes finds it all a bit much.

ii. Progressive narratives:

The narratives of fourteen families had a progressive structure, i.e. described some beneficial change in relation to child development and/or the child's developmental environment that parents associated with service use. Analysis of the narratives showed one important difference in the outcomes. Nine narratives (ten children) showed the parents had no remaining concerns for their child after service use. These narratives spoke of positive changes and held evidence of no further concerns. These were therefore sub-classified as progressive 'satisfactory' narratives. Table 20 shows that these narrative structures were associated with use of a range of services:

Table 20: Progressive Satisfactory Narrative Structures

Service	N
Drop in (Next Steps)	1
Referred by professionals SSCCW, SSHV, funding	4
Requested help SSCCW, Counsellor	4
Total	9

Where a follow up data collection was possible - up to one year after initial service use - it was found these changes had endured, e.g.

Participant 10. (Sure Start Child Care Worker).
Mum was impressed with the service, and she feels it helped her relationship with H., She now knew how to interact with him, was able to sit down and play with him, and knew how to deal with difficult behaviours such as tantrums. This has meant Mum is able to cope with his difficult behaviours and does not get so upset by them. H's behaviour had improved and Mum is no longer worried he has a disorder. She has recommended the service to friends. Mum did learn about another Sure Start service from her SSCCW but doesn't use it as getting there is too hard as she doesn't drive. Mum has no concerns about H.
Six months later Mum felt H's behaviour was still better than it was before service use. Mum is still able to sit and play with H and the family still use techniques learnt from the SSCCW to deal with difficult behaviours. Mum is still finding it easier to cope with any bad behaviour. Mum also feels she has become more involved with H and a bit more relaxed about the mess he makes. Overall Mum feels the service has had a lasting effect mostly demonstrated by H's better behaviour. H. is about to start school next week and Mum said she had no real worries about this.

The other five accounts (six children) with progressive narrative structures talked of improvements associated with service use but a further theme also emerged in the form of enduring or new developmental concerns. These were sub-classified progressive 'unsatisfactory' narratives. All of these children had been referred to services, four to SSCCWs and two for Assisted Funding,e.g.:

Participants 23 and 24, (Assisted places)
Mum feels she has 'got her life back' since play group began, as she can do things such as visiting relatives or clean the house without them being involved. Mum said she felt much happier, better in herself. Mum feels both children have calmed down, and that L is not as naughty as he used to be. Mum also feels the children have come on brilliantly in school. However the activities they do at play school do not appear to have changed the things Mum does with them at home, home amusements are still limited to television and playing by themselves. Mum is still finding T difficult as she is demanding a lot of

attention when home, which Mum finds annoying. Mum has heard about another Sure Start service - the Toy Library, her Health Visitor told mum about it and said they took children on the bus and did things with them. Mum hasn't used it yet, she feels it is a lot of trouble to take the twins places. It appears Mum is still suffering from post natal depression as she mentioned her GP would like her to start taking antidepressants again, but Mum herself is not keen.

iii. Regressive narratives:

Four narratives suggested that the focus child's development or developmental environment was felt to have deteriorated. One family had failed to use the service at all. Three families had fully used their services (Mother and Toddler, SSHV, SS Counsellor), and their narratives showed that parental concerns for the child had appeared during the time of the study. Each account included some description of negative change in the child's development or environment despite service use, e.g.:

Participant 22 (Sure Start Health Visitor, SSHV)
Immediately after service use: Mum felt the service was fantastic, H is sleeping through the night now. A lot of the plan was common sense but she had got to the point where she was so exhausted, she didn't know what to do. She feels having someone else involved works, as it gives you a bit of confidence that you can do it but on your own it can be too much. The family had the SSHV's telephone number now, any problems and she will come. She plans to come and see him in six to twelve months just to see if he is OK. H's sister is doing well at school now. She's getting good sleep, and once she had caught up all was well.

One year later: Mum describes H as fine, but hard work. The generic Health Visitor suspects he is suffering from a hyperactivity disorder and that this probably explains the sleep problem. Mum feels it's a relief to have a 'sort of' diagnosis, but the Health Visitor has told her there is nothing that can be done until H is school age, not even to get a proper diagnosis. In relation to the sleep problem: within a fortnight after service use the family was back to square one. Mum acknowledged that the program worked but felt it didn't take into account the living situations of people. In their case, she couldn't let H cry for 2 hours as she has another young child in bed, a husband on shifts, and neighbours that can hear everything. H does get to sleep more easily but wakes 3 or 4 times a night, wakes up mum and gets up. Overall mum feels the SSHV was fantastic but usually deals with children who have got into bad habits, not with children who may have disorders that affect their behaviour. Mum feels she is very lucky to have her generic health visitor as she is very supportive, but she feels there is no other help available so they must just live with the problem. The family has not seen the SSHV again, or used/come across any other Sure Start services. There are few activities in her area anyway and Mum feels any parental support or socialisation is generated by the local community here.

iv. Incomplete narratives:

Five participants only took part in pre-service interviews. Three did not respond to invitations to take part in phase 2 data collection. Two participants stopped using

services, but gave some feedback to the researcher, as these were both multi-risk families this is discussed in later sections.

iv. Summary.

After using services some families felt nothing had changed, some felt their child or their child's environment had improved in some way, while a few that their child's developmental progress had deteriorated.

- Eight families (nine participant children) with stable structures felt their situations had not changed. Six narratives described satisfaction with their child before and after service use and had not used the service because of concerns. Five families with this narrative structure had used 'drop in' services as part of their routine, and the other had been referred to 'Talkabout' by her school teacher. The mothers viewed the service as good but as not having a real influence on their children as they were already progressing well and doing lots of activities. Those with unsatisfactory stable narratives, two of whom had received services after requesting help for their child and the other who had used a 'drop in' service, felt service use had not really changed their or their child's situation.

- The narratives of fourteen families (sixteen participant children) had a progressive structure, i.e. associated service use with some improvement in their child's development or their child's developmental environment.

  The nine parents of the majority (ten) of these participant children had no remaining concerns after service use. Four of these families had used services after asking for help, one family (two children) had used a 'drop in' service, and the remaining four families had been referred to service use by health or educational professionals.

  Five accounts (six children) talked of improvements associated with service use but also of enduring or new developmental concerns, All of these participant families had used services after referral spurred by professional concern.

- The narratives of four families had a regressive structure. One account is irrelevant in this section as the family did not engage in service use after referral.

The other parents felt the child or the child's situation had deteriorated since service use began. Two mothers had not been concerned about their child's development at the time of initial service use, but concerns had developed during or after service use. One mother had been concerned before use, and her narrative shows initially she thought the child's problem had been solved, but this early progression disappeared once the service was withdrawn. The situation is now worse as the mother has has no further contact with RCTSS, and has been advised by a generic health visitor that her son probably has a condition which cannot be treated at present, and no referral to futher services i.e. to clinical psychology services was offered.

e. Families after service use:

Themes emerging after service use were explored, with the interest in whether all needs and problems likely to impact on the children's development and had been recognised or met; whether the child had any problems left, either the one that originally led to service use, or a new issue; and whether any monitoring or service contact had been provided.

i. Families with no concerns after service use:

Fourteen participant families (sixteen focus children) held no developmental concerns after service use.

Within these families, five (six participant children) had given narratives with stable satisfactory structures, i.e. they had never held any concerns about their child or their situation, e.g.:

Participant 13, p.14,, (mother and toddler)
Researcher: ..... and how is she?
Participant: A monster!
Researcher: (laughs) so you have no worries
Participant: No she's coming on nicely, school soon now which will be good
Researcher: Yes next term isn't it, that's why I've come now.

Nine participant families (ten focus children) gave narratives with progressive satisfactory structures. These families felt the service had helped and voiced no concerns after service use, e.g:

Participant 33, p.22 (SSHV)
Participant: Generally he is happier, sleeping better and gets more out of his day.
Researcher: Well yes, no other problems then
Participant: No, we're lucky.

Participant 10, p.14 (SSCCW)
Researcher: So do you feel it has had a lasting effect?
Participant: Well yeh, because mainly his behaviour is so much better, definitely better
Researcher: And that is what you wanted wasn't it? To have him set up better to go to school
Participant: That's right before he starts now next week
Researcher: So any concerns left
Participant: Well I'm still looking forward to the rest when he starts but no real worries.

The narratives of all these families revealed that no families had received monitoring or contact from RCTSS once initial service use had ceased, and none had been referred to other services. The only extended use was found in two children who had moved up to the Sure Start playgroup associated with their mother and toddler group.

ii. Families with outstanding needs:

Within the narratives gained from twelve participant families (thirteen children) were concerns about the development or the developmental environment of children after service use. The narratives of three families categorised as unsatisfactory stable structures contained concerns or problems similar to those before service use, e.g;

Participant 8, p.24 (SSCCW)
Researcher: the physical, ummm hitting and stuff
Participant; Oh yes he still does that, but it's the language now. His language is terrible the things he says. I don't know what to do about that. Terrible.
(later)
Researcher: ..... and are you managing, coping...
Parent: Some of the time, but sometimes I get umm.....
Researcher: So if there were something available to help you manage their behaviour or at least
Parent: Yeh, Well with the eldest, at the moment I'm trying to get in contact with the Health Visitor to get him to see a psychologist. With N. (elder brother) a lot of things have been happening, like I've split with his father for about 8 years, he doesn't like that...and he was 5 going on 6 before I had him, so he's jealous, so I'd like to get him in to seeing someone.

None of these three families were in contact with Sure Start at the time of the final data collection visit, although the child with the eating problem was awaiting an appointment

with a dietician which had been arranged through the generic health visitor at the same time as the Sure Start referral.

At the time of initial service use five family narratives (six focus children) talked of concerns for their children, and of other problems such as isolation, maternal depression, poor transport, and/or referral to or evidence of lack of developmental stimulation in the house. These accounts were categorised as progressive 'unsatisfactory' narratives as problems were still talked of after service use, e.g.

Participant 21(SSCCW)
Mum still does not go out much because: she doesn't know what is available in the area; getting places, even getting the pushchair down the steps is a challenge as they live on a really steep hill, so it has to be bus all the time: Mum is very cautious of other people in the area.

Participants 28(SSCCW)
Parent: .....as I say it was not exactly what I thought it would be, and she was great, but I think somewhere along the line the wires crossed, and I just wish..... he have calmed down, I did explain the situation, I think they sent the wrong person into the wrong situation. Because if someone could just have said this is how you keep in the car seat, because I've been driving down the motor way crying, cos I've had to stop the car so many times for him. And he lies across the car the back.....and one day I'll be stopped by the police, and they think I let him carry on.....and it is things like that.

These families were not in touch with any Sure Start services or with other agencies at the time of the final data collection. One was about to use an additional service suggested by both her health visitor and her SSCCW:

Participant 30 (SSCCW & SS Counsellor)
Parent: ..... it's like the SS woman is inside my head fixing it all out, but this last week, it's been depressing and it's getting me down, but they always say it will get worse before it gets better. It has been worse, I've been getting migraines, but I'm trying not to think about it, and I do get my good days and I know how to get myself out of the whole situation
(later)
Researcher: ..... and did she leave a way you can contact her , or did she say that you could
Parent: She's going to get in touch with me anyway, 'cos I'm getting Home Start now, they are coming next week, don't really understand all that to be honest,

Four families, including one who had not used their initial service, gave narratives with regressive structures. Parents talked of new or enduring increasing concerns in the final study visit, e.g:

Participant 16 (mother and toddler)
..... actually his childminder now, she thinks his talking is poor...I don't know, boys can be a bit slower talking sometimes ...so we're keeping an eye on it for now.
Researcher: see how he goes?
Participant: yeh, cos he doesn't start school for a bit so there's no hurry...but if he doesn't come on soon we'll have to get some help
Researcher; Mmmmm.....so the group didn't really have any particular effect?
Participant: Umm.....no, he was only there once a week and we go to lots of other things,

Participant 1(SSCCW)
Participant: .....his behaviours because he likes his tantrums so much...and he won't share his toys...like that book with you now, his cousin was here and he wouldn't share at all

Three of these families were not in contact with RCTSS at the final meeting. The family who had failed to use services initially were just about to begin working with the SSCCW after a clinic meeting with her generic health visitor.

iii. Summary.

After service use participant families could be divided into those who had no concerns or problems and those who did:

- Fourteen of the original participant families had no concerns. Five families (six focus children) had not been aware of concerns or needs before service use. Nine lower-risk families (ten focus children) had only spoken of the concern or need which led to initial service use, and all associated alleviation of the needs with Sure start service use
- The theme from the narrative of twelve families (thirteen focus children) was that they still had concerns for their children or lived in developmental environments which gave cause for developmental concerns after service use. Only four of these families had been referred to or made aware of further services

The twelve families with further concerns included the six multi-needs families recruited to the study who had taken part in all the data collection phases. The final section in this chapter presents findings drawn from the experiences and outcomes of multi-needs families during their association with Sure Start services.

6.6. Multi-risk families

Seven families (eight focus children) lived with multiple developmental risks in poor environments.

a. First contact with services.

Four participant families had held no particular concern for their child before service use, and had been referred to RCTSS through health visitor concern, mostly concern about the amount of stimulation the child was receiving e.g.:

Participant 2 (SSCCW)
Researcher: Your health visitor suggested you have someone come to help you with the baby?
Participant: Yeh,
Researcher: Do you know why?
Participant: No……well cos he's new …….and my first I suppose

Amongst the rest, one mother was referred to a counsellor, and one referred to funding for play group. The final mother of a multi-risk family had been concerned about her child's violent behaviour, and had been referred to RCTSS services after asking for help in a discussion with her health visitor.

Participant 8(SSCCW)
Participant: Well J is behaving so bad at the moment, so I said to * (Health Visitor) and she said would I like someone to come and help me with him
(later)
Yeh, but my mother gets frustrated with the baby, he do really batter her sometimes.

Attitudes towards service use amongst the mothers in multi-needs families varied. The mother of the twins was glad to get the funding to allow the children to attend play group, and the mother who had asked her health visitor for help with her child's behaviour appeared positive about the incoming service:

Participant 8 (SSCCW)
Researcher: And how did you come to use Sure Start?
Participant: Well J is behaving so bad at the moment, so I said to * (Health Visitor) and she said would I like someone to come and help me with him
Participant: So I said 'yeh' , tell me what to do like
Researcher: Do you know what they will do?
Participant: No, not really…sort him out I hope.

Attitudes varied among the other families, some mothers expressed little opinion about service use, e.g.

Participant 1(SSCCW)
Researcher: OK, but you think someone else might be coming?
Parent: Yeh
Researcher: So how do you feel about it?
Parent: I don't mind

Participant 17(Counsellor)
Mother: I'm going to see her on Tuesday. Just to talk about it really.
Researcher: Well, it sounds like that might be a really good idea, what do you think?
Mother: Mmmm..... hope so, we'll see.....

Whilst two mothers held negative attitudes and appeared reluctant to take part in the service they had been referred to:

Participant 2(SSCCW)
Participant:, but I don't know cos when the woman was coming when I'd just had *.....I mean she was coming every day, I don't like..... cos she had to like for the baby..... but after a while she got on my nerves,
And the health visitor she didn't really say much like , she's.....just up the clinic.

Participant 32 (field notes, SSCCW)
She doesn't know what the Child care worker will actually do but she intends to 'blank out' any stupid ideas the worker may have.

As found among many participant families in this study, the participant multi-needs families held little or no knowledge of the services before use e.g.

Participant 2 (SSCCW)
Researcher: And what do you think you'll be doing?
Participant: Dunno, just stuff with the baby I suppose,

b. Assessment

Six families (seven focus children) were referred to services to meet the concerns of health and educational workers, which suggests some assessment of the children and the family situation. As commented in Section 6.4.b. no comprehensive assessment appeared to take place within RCTSS services.

c. Service use.

Three families did not fully use the SSCCW service, and services were withdrawn from these three families. The attitudes of two of these families before service use had been negative or non-committal, e.g:

Participant 2 – from telephone conversation- (SSCCW)
The family has discontinued service use. The SSCCW called twice, and played with K. Mum said it was 'alright' but she couldn't really see what they were getting out of it. She missed the SSCCW a couple of times, because she was getting out of the house more. The SSCCW then stopped coming.

Although at the second data collection one mother said she would still have liked to have had the service but problems in other areas of life had prevented her utilising the SSCCW

Participant 1,p.14. (SSCCW)
Researcher: .....can you tell me, I mean last time, I wasn't quite sure, last time, I mean you know when your Health Visitor suggested someone might come, what did you think it was all about?
Parent: mmmm...not sure...really..mmmm..things with the baby
Researcher: Was it something that you wanted, or had it not occurred to you?
Parent: I did want it in the beginning..but..
Researcher: Mmmmm
Parent: We just got busy...back and fore to the solicitors in Cardiff
Researcher: Is that where you had to go?
Parent : Yeh.... And.....see we were getting married in February last year, but I kept holding off, cos when I was expecting him I wasn't feeling well, so then we got married in July then,
Researcher: That's right 'cos you were just getting ready when I saw you last
Parent: Yeh,
Researcher: Does that mean your husband can stay now or not?
Parent : No..

Of the four multi-risk families who had fully used services, narrative analysis showed that two families felt their children had enjoyed the SSCCW service,

Participant 23 & 24, p.13 (Assisted places)
Parent: .....ah, like.....well since they have been in playgroup, it's like I have got my life back
Parent: Having the other children around and he loves the teachers, he will run in and give them a hug, kiss and.....I think it is not , just well it's not fair for them to be just stuck in the house, they don't go any where. And when I take them to school...I don't think L has ever had a day off since he started.

but that the mothers themselves had not become very involved:

Participant 21, p.3 (fieldnotes, SSCCW)
The sessions include the worker coming with toys, L likes it when she comes and she has been playing fine motor skills games and teaching him body names. Mum sits and

watches, she does not get down and join in, and feels that the sessions are for him to play not for her.

While the mother who saw a Sure Start counsellor felt the service had provided important support:

Participant 17p, 6(fieldnotes, Counsellor)
When asked how different she felt, mum said she felt the sessions had helped her become physically and emotionally stronger. In practice this helped her as she understood why she was having flashbacks, and these have now stopped.

No participants used further services. Five said they had not heard of any. Two parents (three children) had heard of other services, but cited age, financial concerns, lack of awareness and disinclination as reasons for non-use , e.g.

Participant 23 & 24(Assisted Places)
Parent: No, I don't think so, Mm, well I heard of toy library
Researcher: Right, and did you use it
Parent : No.....well you know , it is the hassle of taking them both up there in the buggy, and well....I just didn't.

d. Service evaluation.

Use of Gergen and Gergen's (1984) model showed that of the four families who had used services, three families (four children) felt some improvements had occurred,

Participant 21p. 4 (SSCCW)
Mum feels this has had an effect as he is playing more..... She feels the service has been worth while.

Participant 17, p.6 (fieldnotes, Counsellor)
When asked if the sessions made a difference, she said they definitely did and she knows this because she had to fill out some kind of questionnaire before and after sessions and these demonstrated changes in her answers. When asked how different she felt, mum said she felt the sessions had helped her become physically and emotionally stronger. In practice this helped her as she understood why she was having flashbacks, and these have now stopped. As a parent as she felt she was being a lot more tolerant as she had the emotional energy to answer their questions, rather than asking to be left alone, and she was spending more time playing with them, and talking with/to her daughter .....felt her understanding of her daughter was better.

However as all the three narratives referred to ongoing concerns or issues these three narratives were categorised as having a progressive unsatisfactory structure.

One other mother felt service use had made no real difference, and her narrative was classed as stable unsatisfactory:

Participant 8, p.17 (SSCCW)
Researcher: Bout six, and would you say anything changed in Josh, since that?
Parent: Umm.....no, not really
(later)... ... .
Researcher: Yes, he's quite sociable now, and did you learn anything from it?
Parent: No, not really

e. Multi-risk families after service use.

When asked about their lives, needs and problems over the course of interviews, families talked of concerns about their children and/or problems in their lives e.g..

Participant 21, p.4 (SSCCW, fieldnotes)
She has never been asked about her needs and doesn't feel her needs have been taken into account.

Participant 8, p.18 (SSCCW)
Parent: It's like if every thing just goes over the top of my head, nothing gets to me, and that's what I want really innit, you know with two kids on your own, and you know, it's a nightmare.
(later)
Parent: Then he (children's father) does nothing now. .....got mental health problems...Through drugs

And concerns for the children or the family remained after use, e.g:

Participant 1, p.19 (SSCCW)
Participant: so I'm just here on my own.....It will be better when we move and make new friends over there.

Participant 17p.7(field notes, SS Counsellor)
However she does have concerns of the effects of relationship breakdown on the children especially her daughter, who is complaining of tummy ache, and her behaviour has deteriorated. .....
The relationship of mum and J's father has been under pressure for a while. Mum wants to move back to where her family and friends are, her partner refuses to go, Mum feels that if he can't show commitment in that way then she is not interested. She says he makes her feel worthless and her friends have said he has a rotten effect on her. She has changed become 'scared' and lost her self confidence. She was upset at the way he would not keep arguments until the children were elsewhere or asleep, meaning the children were witnessing lots of arguments. He has been thrown out of the house before, and he slept on the sofa last night and she has told him to leave today.

At the time of the final study visit only one family had any contact with Sure Start. This was the family who did not use services initially and been offered the SSCCW service again during a visit to the baby clinic.

f. Summary.

- All of the children in this group lived with multiple developmental risk factors in poor environments
- One family had held concerns for their child before service use. They had been referred to a SSCCW for help with the child's violent behaviour
- None of the other six families had been concerned about their seven focus children before service use. Four referrals were made to SSCCW's because of generic Health Visitors concerns about the child's development, one to a SS Counsellor to meet a Health Visitors concerns for a mothers mental health, and the twins in one family to playgroup funding after the mother had been told about playgroup by the playgroup leader
- Attitudes varied: the mother referred for funding, and the mother who had asked for help with her child's behaviour were keen for the service; others were non committal or negative
- Pre-service knowledge was poor
- Three families did not use the service fully and the service was withdrawn. The other five families used the service fully, but two mothers using the SSCCW service did not appear to become very involved. Children using the assisted places and the SSCCW service had enjoyed it. The mother using the counsellor felt the counsellor had given her excellent support at a difficult time
- Narratives suggest the following factors may be barriers to service use:
    1. Reluctance to become involved in the service.
    2. Lack of knowledge about the service before use – the 'point' of service use.
    3. Low parenting knowledge.
    4. Disinclination to use services.
    5. Age –services for younger mothers.
    6. Money – lack of knowledge about how much services cost
- No further services had been used by those using initial services, but one family had been re-referred to the SSCCW after failing to use it first time
- By the time of the final data collection five families had finished Sure Start service use. The child with violent behaviour was still violent and still delayed. The child with motor problems was playing more, but his development was still

delayed and his environment continued to be poor. The mother who had seen the counsellor felt much better, but was concerned about her children's behaviours as the parental relationship was breaking up, and her son demonstrated a developmental delay which had not been present at the first data collection. The twins using playgroup were behaving better, but mother was still finding one child difficult and their home environment remained poor. The other children had not received a full service

- After service use, all but one family were concerned about their children, and all children for whom data could be collected demonstrated developmental delay

Having presented themes which emerged from participant accounts of their service use, the next section will begin by investigating whether parents' perceptions of the changes in their child or their child's environment are validated by the quantitative assessments undertaken.

6. 4. Post service use quantitative findings.

To provide systematic measures of participant children's developmental progress during their time of service use, quantitative assessments (ASQ, ASQ:SE, Appendices C &D) were carried out. To assess the developmental environment, pre and post service use HOME assessments were performed (Appendix E). The sections below consider these developmental assessments.

a. Child developmental assessments.

ASQ and ASQ:SE measures assessing the communication, motor, problem solving, social and emotional developmental status of each focus child before and after service use, were obtained for 29 of the original focus children. The second data was collected in the first visit after the episode of initial service use ceased, or six months into use of a long term service. Children who reached the 'cut off' competence line in every developmental domain were classed as developmentally competent, otherwise they were categorised as non-competent. Table 21 shows that the total number of 'developmentally competent' children increased by two over the time of initial service use.

Table 21: Developmental status before and after service

Developmental area	Before use	After use
Competent	15	17
Non competent	19	12
Sub-total	34	29
Attrition from study	0	5*
Total	34	34

*Three of these children were non-competent before use.

Crosstab contingency tables were constructed (Table 22) to give more information about changes in the pre and post intervention developmental categorisation of focus children:

Table 22: Focus children's development before and after service use (ASQ & ASQ:SE).

		Competence phase 2 No	Yes	Total
Competence phase 1	No	10	6	16
	Yes	2	11	13
Total		12	17	29

Table 22 shows that,

- Eleven children were developmentally competent before and after service use
- Ten children were not developmentally competent before or after service use
- Two children moved from competence to non competence over time of intervention
- Six children moved from non competence to competence over time of intervention

The individual scores of participant focus children taken after initial service use (Appendix O) also showed that:

- Four children still deemed non-competent had reduced the number of domains of non competence after service use,
- Two children remained non-competent but had increased the number of domains of non competence during service use.

Contingency tables were constructed separately for the ASQ and ASQ:SE assessments. Table 23 shows pre/post changes in ASQ developmental domains.

Table 23 Changes in ASQ scores over time of initial service use

		ASQ competence phase 2 Yes	No	total
ASQ competence phase 1	Yes	14	3	17
	No	4	8	12
Total		18	11	29

Table 23 shows that in the areas of communication, problem solving and motor skills:

- Fourteen children were developmentally competent in all areas before and after service use
- Eight children remained 'non competent' in at least one developmental area despite service use
- Four children achieved full developmental competence during their time of service use
- Three children became developmentally non-competent in at least one area assessed, during their time of service use.

Table 24 summarises the socio-emotional progress of focus children during their time of initial service use.

Table 24: Changes in ASQ:SE competence scores over time of initial service use

		ASQ:SE competence phase 2 Yes	No	Total
ASQ:SE competence phase 1	Yes	20	1	17
	No	5	3	12
Total		25	4	29

Table 24 indicates that:

- Five children who displayed socio-emotional delay before initial service use moved to socio-emotional competence during initial service use
- One child became socio:emotionally non-competent despite service use
- Twenty children remained socio-emotionally competent throughout
- Three children remained non competent

McNamar's test was used to signify whether there was a difference in the proportion of children that moved from competent to non-competent, and those that moved from non-competent to competent (Table 25). The results indicate that there was no significant pattern in the direction of change between competence and non-competence in the areas assessed for focus children, pre and post service use.

Table 25: Significance of pre –post changes in participant children's competence.

Assessment	**p value**
ASQ & ASQSE	0.29
ASQ	0.99
ASQSE	0.22

The main purpose of collecting the quantitative assessments was to discover whether they validated the perceptions of parents regarding the effects of RCTSS on the progress of their focus child. Table 26 links the changes identified by the ASQ and ASQ:SE assessments with the perceptions of the parents about the effect(s) of service use on the focus child.

Table 26: Focus children's development before and after service use. (n=29)

Pt. No.	Before service use		After service use		Narrative structure
	Competent	Non-competent	Competent	Non-competent	
3		*	*		PS.
4		*	*		PS
10		*	*		PS
20		*	*		**US**
34		*	*		PS
22		*	*		R
17	*			*	R
19	*			*	**PS**
5	*		*		**PS**
6	*		*		**PS**
12	*		*		SS
13	*		*		SS
18	*		*		**PS**
25	*		*		SS
26	*		*		SS
27	*		*		SS
30	*		*		**PU**
31	*		*		SS
33	*		*		**PS**
7		*		*	PU
8		*		*	US
9		*		*	PU
15		*		*	**US**
16		*		*	**R**
21		*		*	PU
23		*		*	PU
24		*		*	PU
28		*		*	PU
29		*		*	**PU**

PS –Progressive Satisfactory, perceived improvements no concerns left after service.
PU- Progressive Unsatisfactory, improvement but concerns remain after service.
SS –Satisfactory Stable, no change, no concerns before or after use.
US- Unsatisfactory Stable, no change, concerns persist after use.
R – Regressive, child felt to have changes for the worse during/after use.
Bold type in Table V signifies disparity between parent perception and the assessment results

Parent perceptions were supported by the ASQ and ASQ:SE assessments of nineteen of the twenty nine children from whom longitudinal data could be collected. Consultation of participant narratives provides possible explanation for some of the apparent disparities for the other participant families, this will be considered in the discussion chapter.

b. Summary

The present study is exploring changes in the development and the developmental environment of focus children during the time participant families were associated with RCTSS. In this section, the overall ASQ, ASQ:SE results suggested Sure Start services could be associated with little improvement in participant children's development or developmental environments. However, inspection of individual developmental assessments identified a number of changes in the developmental changes of a proportion of individual children. Results also indicated that for the majority of children, assessments supported the perceptions of mothers about the effects of service use.

6.7. Conclusion.

Data collection was carried out in three phases before, during and after initial service use. This chapter described the study sample, explored the developmental contexts of study participants before RCTSS service use, and investigated their experiences of service use as well as changes in children's development and developmental environment over this time.

Results showed that one quarter of the study sample (23.4%) were families living with multiple risks in poor developmental environments.

Qualitative findings showed participant families came to use Sure Start services in one of three ways: through use of 'drop in' services; because of concerns of the families; or as a result of concerns held by educational or health professionals.

Attitudes to service use were good in those families using 'drop in' services or who had asked for help, but varied among those referred by staff from other agencies.

Knowledge of local services – including some Sure Start services - was good among families who used the 'drop in' services, but poor among other participant families.

Expectations about the effects of service use varied : most users of 'drop in' services hoped their children would benefit but viewed the activity as part of routine daily life; those who had requested help anticipated some beneficial impact as a result of service use; the expectations of those referred to services by professionals were diverse, some

thought the service would be helpful, some had no expectations and others said they would wait and see.

Most families used their initial service. The three families who had failed to use services were all multi-risk families who had been referred to a SSCCW by their generic health visitor. Of those who used services the majority felt the services were of good quality and enjoyable. However there was little evidence of initial service use leading to a greater awareness of, referral to, or use of further Sure Start or other local agency services.

Developmental changes were perceived by many families over the time of services use: the accounts of sixteen families showed that they had perceived some developmental changes in their focus child/children which they associated with service use; nine accounts did not refer to any developmental changes during service use which they attributed to service use; and four families felt their child or their situation had deteriorated during the time of services use. Before service use, six families had held no concerns for their children. By the time service use ceased sixteen families held no concerns. The final data collection identified thirteen families whose child, despite input by RCTSS, was causing developmental concern or lived in an environment which suggested the original or further problems or concerns existed.

The amassed scores from the ASQ & ASQ:SE assessments indicated that there was little change in the numbers of developmentally competent children during their association with RCTSS service use. Crosstab contingency tests, together with inspection of individual developmental scores showed that a number of developmental changes did occur.

Comparison of parents perceptions of the effects of service use with the ASQ and ASQ:SE results suggests that that, for the majority of participant children, the quantitative data supported the qualitative findings, i.e. parental perceptions of changes in their child.

The first part of the next chapter discusses these findings. This will be followed by sections relating participants' experiences of RCTSS service use to Guralnick's Developmental Systems Model (2001, 2005). It is hoped this exercise may identify areas

where changes in RCTSS service provision – to better meet the recommendation underlying the DSMEI - may lead to improvements in the impact and efficacy of their services.

CHAPTER SEVEN: Discussion

7.1. Introduction

No national early intervention programme existed in the UK until the creation of Sure Start in 1998. The first 'wave' of Sure Start Local Programmes (SSLPs) reached across England, Wales, Scotland, and Northern Ireland, bringing the service to many of the most deprived areas within the UK. The ongoing National Evaluation of Sure Start (NESS) is concentrating on the work of English local agencies and to date has provided a body of information about the implementation and impact of their services in English Sure Start areas. Within Wales no national evaluation of the programme was established. SSLP's have been set up throughout the principality located in many of the most deprived areas, including Rhondda Cynon Taff in South East Wales. Rhondda Cynon Taff Sure Start (RCTSS) is a local programme which differs from many others as - since conception, and in recognition of the widespread deprivation in RCT- RCTSS has offered Sure Start services on a county, rather than area based, level. Previous research evaluations of RCTSS (Glossop & Macdonald, 2002; Haywood & Macdonald, 2003; Boot & Macdonald 2004) raised some important questions about RCTSS including: is the agency reaching RCT families most in need; are RCTSS services recognising and meeting all factors likely to impact on the development of children and families using their services; are services benefiting child development? To seek answers to these questions the main objectives of this study were:

- To discover whether RCTSS services reach the more disadvantaged children in RCT
- To explore whether services recognize and meet the needs of services users
- To report on the development of children associated with service use, and discover whether parents felt RCTSS services could be linked to perceived developmental changes
- To identify factors which appeared to mediate or prevent/limit effective service use
- To provide practical information to enhance the services offered by RCTSS
- To explore the process of applying the DSMEI to the services of RCTSS

These objectives were addressed by use of a short term longitudinal cohort study. During this, data were collected in up to three phases: before; during; and after the time of

participant families' service use. During data collection a questionnaire, standardised quantitative assessments and interviews were used to explore:

- The needs and contexts of participant children and families before RCTSS service use began
- Participant experiences of service use
- Focus children's development and developmental environments while associated with Sure Start

Chapter six presented the study's empirical and qualitative findings.

The following chapter begins by summarising the study's findings and relating them to evidence drawn from the available literature. The chapter then continues to place participant experiences of Sure Start service use within the theoretical framework of a systems approach to early intervention as presented in the Developmental Systems Model of Early Intervention (DSMEI, Guralnick, 2001, 2005). The intent being to consider whether use of this model of early intervention, along with consultation of its underlying recommendations, may increase the effectiveness of early intervention services such as those provided by RCTSS. The final section argues that when guiding interventional services for hard to reach or vulnerable families the DSMEI may benefit from the addition of some components at an early point within its framework.

7.2. Reaching families and children in RCT.

> *'The people who are not queuing up are the very people who Sure Start programmes, now being launched in thousands of new Children's Centres across the country, were set up to reach: the most vulnerable and at risk, or the ones who are depressed and sitting their youngsters in front of the telly day in, day out. Maybe they are worried that the staff will judge them. Maybe they don't rate baby yoga and breast-feeding lessons. Maybe they are being put off by the yummy mummies.'*
>
> *Griffiths, The Times, September 2007*

Children living with multiple developmental risk factors live with a higher probability of developmental delays and disabilities (e.g. McLoyd, 1998; Duncan & Brooks-Gunn, 2000; Reading, 2004). Although well designed early intervention programmes have been

shown to be effective (Karoly, 1998), the non-participation of disadvantaged families in such schemes and programmes is a common problem (e.g. Barlow, 2005; Bemberg, 2006).

Involving disadvantaged families in Sure Start services and activities is central to the purpose and aims of Sure Start, and discovering whether this was being achieved by RCTSS was an important aim of this study. The inclusive county based policy adopted by RCTSS may have encouraged service use and reduced associated stigma, but it is also possible that widespread service provision made objectives such as: services being within pram pushing distance; that every family in a Sure Start area should gain access to a range of services; SSLP's should endeavour to have a Sure Start centre to focus community interest and engagement (Eisenstadt, 2007; Tunstill & Allnock, 2007), extremely challenging for RCTSS. The extent of the task can be better appreciated when consulting sources which show the average number of live births per year for Rhondda Cynon Taff LHB residents ranged from 2,500 to 2,949 between the years 1996 -2005 (Davies *et al.* 2007). These figures suggest RCTSS are trying to reach a much greater number of children than the average 687 child population served by SSLP's in England (Barnes, 2007). The following discussion will therefore consider the reach of RCTSS to eligible families before considering the access to multi-risk or vulnerable families.

a. Reach to eligible families.

The recruitment phase of this study resulted in the participation of 31 families (thirty four focus children), 7 families (eight children) of whom were categorised as multi-risk or vulnerable. It must be asked whether this was representative of the numbers of new families using RCTSS over a period of six months, as the high number of eligible children and the reports of agency management and staff had led to the expectation that more would have been referred to or used services for the first time over the six month recruitment phase.

Many RCTSS core staff felt the limitations imposed by the recruitment criteria of the study (p.115) had deeply affected overall recruitment numbers by excluding families who had used services previously, but attempts to discover how many families had used RCTSS over a time span of six months failed. This was partially due to the lack of a RCTSS data base, but also because methods of recording service use varied from service

to service. Core RCTSS staff (Sure Start breast feeding advisors, health visitors, child care workers and counsellors) revealed that their services currently use a complicated system to record service use, e.g. over a period of six months 852 client contacts were reported of whom 550 were new clients, but if one family had three members this was counted as three new clients. These figures suggest that the majority of families using RCTSS core services were new service users. No data about the actual number of families or number of focus children involved was kept and no records of the number of families failing to use or dropping out of service use was available. However, evidence collected by earlier RCTSS evaluations suggested drop out rates are high as (Glossop & Macdonald, 2002) found 12% of attempted SSCCW visits failed to gain access for prearranged home visits to families identified as in need of some interventional service and referred to RCTSS by generic health visitors.

Further barriers to recruitment related to the present study were:

- Difficulties in gaining ethical approval from one Primary Care Trust which limited the recruitment phase to three months in some areas
- The finding that some resources were being fully used and could not be extended to new families. This became evident when the Glyncoch family centre reported they could provide no study participants because they had no room to enrol new families during the time of the study, a finding supported in the 2004 audit of RCTSS (Boot & Macdonald, 2004)
- Confidentiality concerns prevented some services from taking part in this study
- Staff offering services such as Dads Matter, Open door and Home-Start were concerned that introducing the idea of taking part in the study might deter clients from using the services at all

These barriers raised concerns about the genalisability of this study's findings, and call for further research, perhaps using some different methodology which would enable these services to take part – this issue is discussed later in this chapter. Whilst visiting agencies during the design and planning stage of this study, it was found that many were difficult to get to and, due to the geographical nature of RCT, travelling between agencies was found to be very time consuming. This may have contributed to the feeling of autonomy found in some agencies associated with and receiving funding from RCTSS e.g. Home-

Start, Safe-Start, Welsh Pre-school Playgroup Association, and Open Doors, a feeling which - together with concerns held by some about alienating service users - may have deterred staff from participating in the recruitment phase. It also raised some doubts about the extent of interagency working amongst the more wide-flung associate services of RCTSS. Despite this, access to and communication with the core team of RCTSS (SSHV, SSCCW, Talkabout, SS Counsellors, the Toy Library, Breast feeding advisors) was easy and frequent. RCTSS core staff were always welcoming, enthusiastic about the study and eager to help in recruitment. As referrals from all generic health staff pass to the RCTSS core staff, the participants recruited to the study were likely to be receiving services which represented those provided by RCTSS core staff.

When considering barriers to service use rather than to recruitment, this study's findings supported those from evaluations of other SSLP's, namely:

- Lack of awareness of and information about services (Simpson, 2002)
- The stigma of service use (Luckock, *et al.* 2002; Simpson, 2002; Johnson *et al.* 2004; Tunstill *et al.* 2005)
- Geographical isolation and transport problems (Simpson, 2002; Killingbeck, 2003; Tunstill *et al.* 2005; Anning *et al.* 2007)

Lack of awareness of services and geographical isolation may be particularly pertinent when providing services over an area like RCT. Many study participant families had not heard of Sure Start before they were referred to a service, while those using universally available activities were often not aware the service was provided or funded by RCTSS. The mother and toddler group was an exception to this; all the mothers knew Sure Start was involved, their associated playgroup was also funded by Sure Start, and mothers found they could access this and other services such as parental education through and in the same premises as the mother and toddler group. This demonstrated how access to one Sure Start service can lead to use of further activities, and drew attention to the concept of multiple services based in single centres.

By the end of this study RCTSS was associated with three centres providing services for children and families. Two centres, that were run in association with Barnardo's and the NCH, had been operating throughout the study, while the other officially designed and

designated as a 'Children's Centre' had just been opened at the end of data collection. These centres appeared to give local child and family services, including RCTSS, a local identity and provide a focus for families and young children in their areas. This was demonstrated by the family centre in Glyncoch, a centre staffed and managed by Barnardo's but fully funded by RCTSS. As mentioned above, this centre was so fully utilised they had no room for new families to join.

The above findings suggest it is difficult to make services well known throughout a wide area, and provides support for the use of centre based services to improve local awareness and facilitate service access. This practice has been recommended for SSLPs (Tunstill & Allnock, 2007), and promises to be realised in the government's pledge to create more Children's Centres throughout England (Balls, 2006). However the finding in RCT that one centre could not offer their services to new families during this study's recruitment phase, together with the fact that many areas of RCT are not served by Children's Centres at all, leaves a strong possibility that the limited resources of established centres, and the lack of Children's Centres in most areas of RCT may have contributed to poor Sure Start reach, due to lack of knowledge about services and poor access to and use of RCTSS services.

The problem of lack of knowledge of services was discussed with RCTSS management and with RCTSS core staff when the present study was complete. The management felt recruitment methods advocated by other SSLP's such as local advertising, leaflets, word of mouth, professional and self referral, working through other voluntary organisations (Barlow *et al.* 2007) had been utilised, while use of a play-bus containing a toy library had been adopted to help take services and service awareness into the community. However, it was felt that further advertising and use of repeated leaflets or regular newsletters may increase local awareness. It may also help RCTSS to remain in contact with reach strategies used by other SSLP's, these include,

- Continual signposting of services to potential users across services and agencies. Continual work with service providers may be needed to support this, as one member of staff complained of lack of knowledge of other RCTSS services

- Employment of workers whose role is to introduce services to families with a new born, or have just moved into the area
- Use of peer workers or buddies to spread the word
- Use of well known community settings – post office, schools, local shops – to advertise services
- Texting to contact young teenage parents
- Recognising social and cultural barriers to reading publicity leaflets and posters, and employing door knocking or telephoning to meet this
- The importance of sensitively targeted publicity to attract specific groups such as the 'hard to reach'

Anning *et al.* 2007, p.61

b. Reach to disadvantaged families.

The RCTSS approach made all families - including disadvantaged families - eligible for service use as long as they lived within RCT. Of the thirty four children recruited, approximately 25% i.e. eight children, were from seven multi-risk participant families. The only available records about overall client contact rates over a typical six month period suggests this ratio of deprived to less deprived children is usual, as approximately 18% of contacts over a six month period were with individuals from Community First areas. As discussed above, it is not possible to show how many families or children these figures represent as this figure includes multiple family members, multiple visits, and the Community First numbers include both new and repeat contacts. Drawing conclusions from these figures is further complicated as living in a Community First area does not necessarily mean that a family is disadvantaged. One illustration of this can be found within this study's participants as four families lived in the same village within a Community First area; two of these were found to be multi-risk families whilst the two others lived in relative affluence providing good developmental environments for their children. Despite this, the finding that only just under one fifth of RCTSS core service users were from the most deprived areas of the county suggests RCTSS services are not reaching deeply enough into areas of severe disadvantage.

Analysis of multi-risk families' experiences of service use suggested that the problems e.g. lack of knowledge of services, transport problems, mentioned above also impacted

on multi-risk participants, but identified further factors which influenced families with complex needs. Six of the seven multi-risk participant families (seven children) had been referred to services to meet the concerns of health or educational professionals while the remaining mother had recognised a problem and asked for help. No multi-risk families had come into contact with services through use of 'drop-in' services. This contrasted to the service use pattern of participant lower-risk families, amongst whom: seven families had been referred to meet concerns of health/educational professionals; seven asked for help to meet a family need or problem; nine families (eleven children) had used 'drop in' services. This suggests that the universally available RCTSS 'drop in' services are less likely to reach multi-risk families, and may possibly give credence to criticism in the press that middle class parents are 'hijacking' Sure Start universal services (e.g. Griffiths, 2007; Miles, 2007, literacytrust.org.uk. accessed 13.09.2007). It also suggests that less deprived families are more likely to seek or initiate use of services themselves to gain help with problems or needs.

When asked what stopped them using local activities some multi-risk mothers mentioned hating the area they lived in, and being suspicious of people in their area, while one mother with depression said she 'couldn't be bothered' even though her generic health visitor kept her informed of local initiatives, including RCTSS. Other reasons given by participant multi-risk families supported evidence found in the literature including: parental shyness or lack of confidence (Sharp, 2002; Simpson, 2002); financial concerns or problems (Simpson, 2002); negative attitudes to professional input (Barlow *et al.* 2005; Tunstill *et al.* 2005; Anning *et al.* 2007), worries about cliques in groups (Anning *et al.* 2007), wishing not to be patronised by staff (Anning *et al.* 2007).

With RCT possessing one of the highest levels of teenage pregnancy in Europe, a greater number of referrals or service use by young teenage mothers had been expected. Although the exclusion of antenatal RCTSS services may have prevented participation of some young mothers, discussions with one health visitor manager suggested that many generic health visitors feel responsible for supporting such young mothers themselves and so do not refer on to services provided by other agencies. This raised the possibility that lack of referral from health services may be excluding some vulnerable families from use of RCTSS services. This suspicion was supported by discussions during the study's recruitment phase during which some health visitors reported they referred any families

they thought could profit from contact with RCTSS, but others said they didn't refer families with complex needs as they didn't think RCTSS was suitable for these families. It is possible that generic health staff feel Sure Start staff lack the requisite skills to work as effectively as they can with very young mothers. This possibility calls for greater interagency interaction to improve knowledge of the roles and skills of all concerned and working with vulnerable families.

In line with Sure Start Guidelines RCTSS should be reaching all eligible children and families in their area. Working from the average live birth rate statistics quoted above, approximately 10,000 children would be eligible for use of RCTSS at any one time. Although figures about the number of families and children using all the services of RCTSS were not available, the number of new contacts for RCTSS core services over six months (550 family members) suggests RCTSS are not reaching all eligible families, including the families living in the most deprived areas of the county. The low numbers of participants recruited to this study over a period of six months (34 children) supports this suspicion, despite the difficulties encountered in including all associated agencies in study participation. The above findings must also be interpreted cautiously in relation to RCTSS. Although the study enrolled participants from many areas of RCT, non-recruitment of participants from two particularly deprived areas of RCT - areas served by two family centres receiving funding from Sure Start – leaves the possibility that the numbers of families being reached by RCTSS are greater than the above findings suggest.

7.3. Recognition of the developmental risk factors and needs of service users.

It is the number not the type of developmental risk factors which increases the probability of a child having developmental disabilities or delays, with four or more existing developmental risk factors associated with the greatest increase in probability of delay (Sameroff *et al.* 1987). Armed with this knowledge, the present study sought to explore whether RCTSS services were recognising all the developmental risk factors of participant children and families. Working from the ecological - development-in-context - perspectives of Bronfennbrenner (1979) and Lerner (2001), phase one data collection gained information about factors believed capable of impacting on children's development. The extent of participant family needs and risk factors was found to vary greatly before service use: eight families demonstrated no needs; sixteen had few (1 -3) needs or concerns; while seven lived with multiple, complex needs. As intimated above,

findings suggest that the number of existing risk factors was related to the way participant families came into contact with RCTSS.

Service users came into contact with RCTSS in one of three ways: through knowledge of local drop in services; referral by health or educational staff; through self referral mediated by their generic health visitor. Participant families using 'drop in' services were all lower-risk families most of whom demonstrated no needs, developmental concerns or risk factors before service use, although it was found that two of these families had used a 'drop in' service to combat feelings of isolation. Participant accounts of 'drop in' service use gave no evidence that use of the activities had led to any attempts to recognise or assess the needs or risk factors of children and families using them. This finding suggests that the likelihood of use of RCTSS 'drop in' services leading to recognition of developmental risk factors and needs is low, but the isolation felt by two families demonstrates that some assessment may have been useful. It is appreciated that using contact at universally available child centred activities to assess or explore the needs of families can be difficult (Kirkpatrick *et al.* 2004). However, the fact that many service users become 'regular attendees,' may give informal opportunities for workers from different services to become seen, familiar, available and ultimately more involved with service users, an approach which Kirkpatrick *et al.* found to be successful in introducing potential services users to other Sure Start services. Kirkpatrick *et al's* work centred on services provided within a family centre and again demonstrated how use of centres can help service users to become aware of and consider use of other activities and services.

Sixteen children, seven in multi-risk and nine in lower-risk families, were in contact with RCTSS services to meet concerns identified by generic health or education staff. All multi-risk family referrals were made to single services and no further RCTSS referrals or activity use were reported or referred to. This suggests that referral was made to meet single or few identified needs or problems. The experiences of three multi-risk families showed that no assessment of their further needs was made, as the one or two early visits they received concentrated on the actual intervention service and these families - each with focus children demonstrating developmental delays – dropped out of further use of the services they had been referred to. Although it has been acknowledged that when a child is felt to possess or be at risk of a developmental delay, the feeling that something must be done quickly can lead to a bypassing of assessment procedures (Guralnick,

2005), the experiences of these three multi-risk families suggests that very early visits may be crucial contacts with families and could be profitably used to recognise the full extent of family needs and to engender positive relationships. In their study, looking at outreach and home visiting in SSLP'S, Ball *et al.* (2006) comment it is important that:

> *'time is allowed for the most disadvantaged families to come to trust the services, This may be a long-term commitment, with little concrete evidence of success at first.'* *p.31*

This comment is supported by the finding that sustained efforts to get to know and engage families can result in better service use by 'hard to reach' families (Weinberger, 2003; Howarth & Foreman, 2006). Established trust could then provide a platform to facilitate further assessment, a procedure which should allow recognition of the extent of family and child needs, and so influence the actual intervention i.e. affect the amount of time and the services used to meet family needs.

A further reason for spending time and effort familiarising multi-risk families with services can be found in a relatively recent review of parental support services which concludes that it is possible to get a large proportion of parents to participate in voluntary services but only if they perceive the interventions as meaningful (Bemberg, 2006). An awareness of the need for and point of services did not appear to exist for the three multi-risk families under discussion, as they had not held concerns for their children or been aware of the services before their referral was made, and were not sure what the point of service use was or what it would consist of at the point of access into services. Within these families, the mothers held non-committal or negative attitudes to home visits and two perceived them as an extra trouble. This finding echoed opinions expressed in a study investigating why mothers did not participate in home visiting intervention programmes (Barlow *et al.* 2005), and supports Bemborg's recommendation that parents should be encouraged and helped to see proposed services as meaningful; an opportunity for support, help or change.

The other four multi – risk families (five children) all used the initial single service they had been referred to, but no further assessment or attempt to identify additional problems or needs appeared to be carried out at any point. According to the families no additional Sure Start services were offered or used at any point. This suggests that all the needs of multi-risk families were not recognised through use of RCTSS services. During contact

with the researchers after service use all of the multi-needs mothers spoke of outstanding concerns or needs which were likely to impact on their child's development e.g.

> *participant 21,(SSCCW, six months after service use):*
> *She does not feel that there has been any change in the things that she does with him since we last met, either in the things they do or the places they go. Mum does not play much with him, and there is not evidence of many play things, just one small box. Mum still does not go out much because: she doesn't know what is available in the area; getting places, even getting the pushchair down the steps is a challenge as they live on a really steep hill, so it has to be bus all the time: Mum is very cautious of other people in the area.*

The nine other families referred to RCTSS by health or educational professionals were all lower-risk. These families were only aware of the concern or need which had led to service use, and no other concerns or developmental risk factors were identified during the study. This suggests that referrals to RCTSS service use made for lower-risk families were often in recognition of the single need. Two lower-risk families were referred to further services to meet multiple needs, but it was noted that these needs were identified by their generic health visitor at the time of referral.

Seven lower-risk families and one multi-risk family used services after consulting their generic health visitor about concerns they had recognised themselves. Six lower-risk families used a single service to address this need, and no further needs or risk factors were identified in these families throughout the study. The other lower-risk family used services for help with the mother's mental health after the birth of her Down syndrome baby. Her generic health visitor referred her to a Sure Start counsellor and to a SSCCW came to work with the baby. At the completion of the SSCCW input, both the generic Health Visitor and the SSCCW recommended long term use of Home-Start to provide support for an indefinite period of time, while the counselling service was continuing at the second data collection. This recognition of the long term needs of a family with a child with learning disabilities, and extended use of the RCTSS network showed that use of initial services could lead to early, sustained, relatively intense service provision as advocated by Ramey & Ramey (1998). This contrasted with the experiences of the final family, a multi-risk family in which the mother had identified problems and asked for help. During the study interviews this mother talked of many problems, but the RCTSS services offered to the family were limited to the single initial SSCCW service provided by weekly visits over six weeks. No other support or knowledge about other service was

offered, and the initial service use did not lead to use of the network of RCTSS services or activities, even though the focus child remained developmentally delayed throughout the 14 months the family took part in data collection.

The above findings suggest that many participant lower-risk children and families used the community based universal services provided by RCTSS on a routine basis, rather than to meet a particular need. When lower-risk families used services to meet a single need, problem or delay, the need had been recognised either by the family or by generic health or education staff. The majority of families, including all multi-risk families, with more needs were referred to single services to address the presenting problem and no further interventions, referrals or services to meet further needs or risk factors were suggested or used. These findings suggest RCTSS service use cannot generally be associated with full recognition of all the needs of families, particularly multi-risk families.

7.4. The development of participant children during association with RCTSS.

As discussed in Chapter 2, there has been much debate about the impact of early intervention programmes on child development, with the consensus that early intervention programmes are capable of positively altering children's developmental progress, but impact is dependent on the type and quality of the programme offered (e.g. Ramey & Ramey, 1998; Brooks- Gunn, 2003). The English National Evaluation of Sure Start (NESS) has provided positive findings from many individual local programmes, and recent findings from their large scale quantitative evaluation have been encouraging as they report on positive impacts associated with: children's social skills and levels of independence; parenting skills; home learning environments; and in more use of services which promote development (NESS, 2008).

Early evaluations of RCTSS (Glossop & Macdonald, 2002; Hayward & Macdonald 2003; Boot &Macdonald 2004) commented on the lack of systematic evaluation of the effect of RCTSS services on child development. Therefore this study tracked the development of participant focus children during their time of contact with RCTSS by use of child development and home environment assessment measures, and by asking parents about the perceived effects of service use.

a. Evidence from assessments

The study's developmental assessments initially appeared to support the early disappointing NESS (2005a) findings, as the ASQ and ASQ:SE assessments showed little change in the total number of developmentally 'competent' children over the time of service use. However, the relatively small sample allowed inspection of focus children's individual scores, and this showed that during service use: six children became developmentally competent; four remained non-competent but decreased the number of non-competent areas; two became developmentally non-competent; two remained non-competent and increased the areas showing non-competence. This movement between developmental competence and non competence showed that developmental changes did occur during the time of service use, changes which may have been concealed if sample numbers had been larger and individual inspection of scores had not been possible. This finding supports concerns that statistical analysis of sample results may conceal changes within individual units (Melhuish *et al.* 2005), and shows the benefit of using assessments to identify changes on an individual basis. It could be argued that using the ASQ and ASQ:SE as a means of assessment was limited by use of parental judgement of children's skills. Although this possibility cannot be discounted, the reliability and validity of parental assessment of their children's developmental levels has been supported (e.g. Glascoe, 2003; Chen *et al.* 2004) and was discussed earlier in the Methods section (p.111).

The developmental assessments suggested changes, many of them positive, had occurred during the period of service use but could not inform whether service use could have been associated with these changes.

b. Evidence from interviews.

Interviews during the second and third phases of data collection were used to gain information about the perceived effects of service use. It was found that:

i. The narratives of most of the lower-risk families who used 'drop in' services, suggest they did not associate service use with any particular impact on their child's progress or environment. The ASQ and ASQ:SE assessments of six children supported this as they found these focus children to be competent throughout. The other two families had used the services to combat isolation, and both mothers felt the families had benefited from

involvement in the activity. The twins in one of these families were found to be competent, indeed scored highly, on all occasions, but the mother felt the service had been useful in providing socialisation for the children. The other mother felt the baby massage had promoted bonding and helped the focus child relax. Despite this positive benefit, this focus child was found to be developmentally delayed before and after service use, although the mother felt her child was progressing well.

ii. Nine of the fifteen lower-risk families who had used services to address problems or delays said that they were left with no concerns after using services, and said they felt the RCTSS service they had used - mostly shorter term services - had been effective. Many of these parents described how service use had impacted on the home environment by changing the way they interacted with the child, or coping with the problem which had led to service use. This parental empowerment was a positive finding as much of children's actual learning happens between early intervention sessions, and makes the whole family central to intervention efforts (Warfield & Hauser-Cram, 2005). These parents also felt service use had had a positive effect on the developmental progress or behaviour of the focus child. Parental perceptions were supported by the developmental assessments for four of these nine children, as their results showed them moving from non-competence to developmental competence during their time of service use. In the narratives concerning three other children in this group, the changes described – in sleeping habits, increased socialisation with child's peers, support for parenting and the mother's emotional health – would not necessarily have been identified by the quantitative assessments used. The remaining two mothers felt the service had been of good quality, enjoyable and had helped their child's communication skills. They had been left with no concerns, but the ASQ identified one area of delay remaining for each child. One of the children, who had been assessed as competent before service use, had had a new baby brother and started school in the intervening interval, and this period of change may have contributed to the delay. The other child demonstrated one area of delay before and after service use, but the specific area of delay had changed.

The experiences of these lower-risk participant families strongly suggests that these parents, parents who had used the agency for help with a particular problem, felt the RCTSS services had positive effects on their child, and in some cases on themselves (socialisation, better sleep). The effects were evidenced in many ways, and some would

not have been identified without use of multiple methods. The common thread from the positive narratives of these families was that they had felt supported and empowered by the intervention, and felt this had resulted in changes in themselves and in changes in their focus child. This supports Anning et al. (2007), who in their report on variations in SLLP efficacy commented,

> *'Confidence to engage in genuinely empowering parents marked out some of the SSLP's as particularly effective.'*

On a less positive note, the evidence that some developmental problems still existed after service use calls for use of some post-service evaluation, a process which could lead to further service provision or the monitoring a child's development if considered necessary.

iii. The narratives of the remaining lower-risk families and the all the multi-needs families who had used services - showed variation in the perceived effects of service use, but all referred to outstanding problems or concerns that were left after service use.

Five families (including two multi-risk families) talked of positive effects of service use, and these perceptions were supported by reductions in the number of delay areas demonstrated in their childrens' assessments after service use. However the quantitative assessments also validated the remaining parental concerns which were identified in post-service use interviews, as each of these children still demonstrated some developmental delay in the post-service assessments.

In the remaining families, one mother felt nothing much had changed as a result of service use, feelings which were supported as her son remained delayed in two areas. The other narratives (including one multi-risk family) talked of some deterioration in the developmental progress of the focus child or in the environment. The perceptions of one mother were confirmed in a follow-up assessment one year after service use had ceased, which showed a return to non-competence. The other two mothers had either remained or become concerned despite ASQ and ASQ:SE scores which deemed the children to be competent. These concerns may not have been identified without the use of a mixed methods approach. These findings again call for some use of follow up and continued contact with Sure Start after service use has been completed.

When looking at the data for all participants it was found that the quantitative assessments performed during service use, when looking in detail (Appendix O) before and after service association, served to validate the perceptions of nineteen parents. When looking at those participants where the data did not correspond, the narratives of five participants (Pt.s 5,6,1,30,33) describe positive effects (increased socialisation, feelings of parental support, better sleep patterns) that would not necessarily have been identified by sole use of quantitative assessments. The quantitative assessments of five other children (Pts.15,16,19,20,29) challenged the perceptions of the parents, a circumstance that called for some further contact with RCTSS either for reassurance, monitoring or further service input. These findings support Moffat *et al* (2006), who when discussing situations when qualitative and quantitative findings conflict, argue that use of both quantitative and qualitative methods is warranted as it provides complementary data that gains a truer version of events. This may prevent premature cessation of services, and ensure all concerns are addressed.

The above finding that many families and/or children were left with concerns after intial service use turns attention to whether RCTSS fully met the needs of participant families and children.

7.5. Meeting the needs of service users.

As discussed earlier, when considering whether the RCTSS services met family needs, it was found that most lower-risk families who used services to address a single delay or need felt that the intervention had been successful and had resolved the initial problem. The quantitative assessments supported this for most of the lower-risk families. As no further problems existed it can be claimed that RCTSS met the needs of many lower-risk families. This was not found for all lower-risk families: one lower-risk mother was disappointed the SSCCW services had not been the 'super nanny' expected and she felt the work of the SSCCW was not appropriate for her child's behavioural problems. This supports Statham (2004) who comments that the poor match of the services offered with family priority needs is a barrier to service use.

Another lower-risk family had felt services had solved their child's (pt.22) sleeping problem initially, but that the child's behaviour had soon regressed. These perceptions were supported by the child's assessments which showed an initial move from

competence to non-competence, but a return to non competence by the final data collection. No further contact with RCTSS had occurred between the final two data collection visits, and - as considered above - this emphasises the need for monitoring and review after service use. This need is also supported by the finding that some post-service use study assessments found children were still demonstrating developmental delays and/or parents were still talking of further concerns, situations or problems that could impact on their children's development. These families included all the multi-risk families.

All the multi-risk families were living with complex risk factors and needs which did not appear to be fully recognised or addressed at any time during family referral to or contact with RCTSS. As discussed above, three multi-risk mothers appeared reluctant to receive the service they had been referred to and soon withdrew from service use with their needs unmet. Two other multi-risk mothers did not engage well in service use and were not referred to further services. Another mother of a multi-risk family, one who had been regularly informed and encouraged to attend Sure Start and other community activities by her health visitor, had only become engaged with Sure Start when offered funding to allow her children to attend playgroup at the age of two and a half; another instance supporting Statham's recommendation that it is important to recognise and meet the priority needs of the family in interventions. One multi-risk mother felt she personally had benefited, but referred to other unmet needs e.g. that her two children – including her son who had been born at 27 weeks, at a low birth weight – were being emotionally and behaviourally affected by her ongoing split from her son's father. All the multi-risk children demonstrated developmental delay at their final developmental assessments, and evidence of enduring parental or environmental concerns was found during the final data phase.

Later discussion of unmet needs with service providers revealed that some workers often wanted to extend their time with families, but felt pressurised to move on to the next family. In relation to this, one worker said she had really been hoping for some recommendations that would allow them to provide the longer term contact needed by many families, especially disadvantaged ones, and remove the continual feeling of having to leave families too soon. These comments raise the possibility that with so many eligible children in RCT, some services are spread too thinly over the area and therefore

staff feel unable to continue contact with families when necessary. When this problem is added to the view that Sure Start services which fully address the complete needs of both parents and young children concurrently are likely to be successful (Anning *et al.* 2007), it suggests some changes in current RCTSS policy to allow fuller more holistic assessments followed by longer more intensive contact with families where necessary, and periodic review of the situation may result in more effective outcomes.

The evidence drawn from the present study suggests that RCTSS are often able to meet the needs of less disadvantaged families, but that their current practice does not lead to the recognition and meeting of the needs of multi-risk families. Attention now turns to placing RCTSS services, as experienced by this study's participants, within the framework provided by Guralnick's DSMEI. The intent is to discover whether this exercise can identify areas where RCTSS service provision could be changed in a way that current research evidence suggests will make services become more effective.

7.6. RCTSS services through the Developmental Systems Model (DSM).

The objectives and principles of Sure Start strongly suggest the agency has adopted a developmental systems approach. As discussed in Chapter 4, Guralnick the DSMEI (2001, 2005), is provided for use:

> *'As a catalyst for communities to examine carefully their own approaches and practices. Considerations by communities, clusters of communities, state-level agencies and even national organisations of strategies to improve the system of early intervention services and supports will certainly be to the advantage of children who are vulnerable and their families.'*
>
> *Guralnick 2005, p.22*

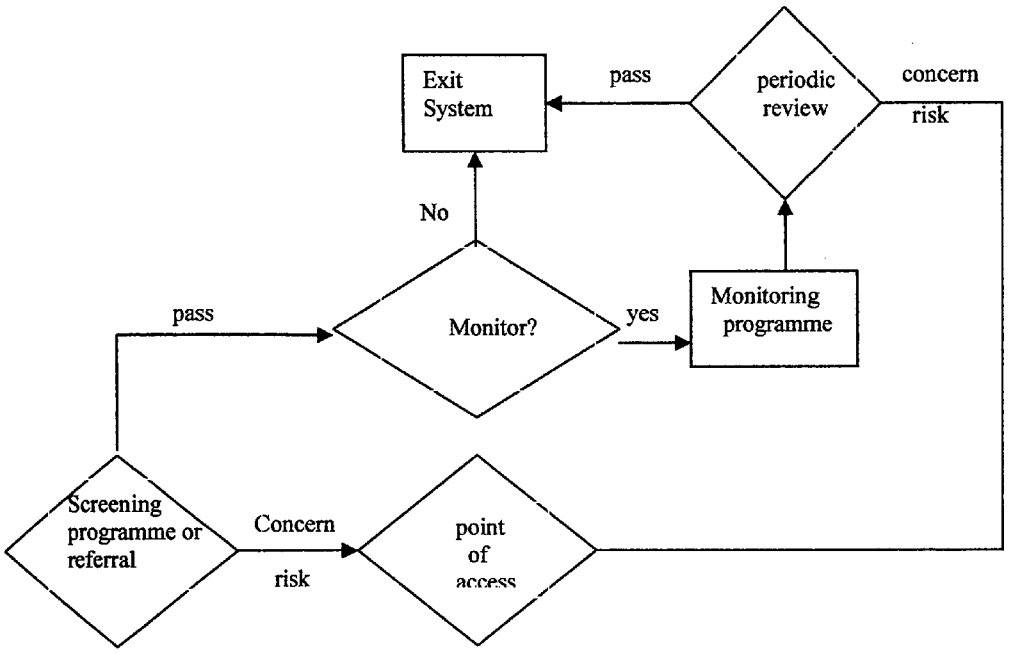
The next section will discuss study participant's experiences of service use through the framework of the DSMEI (Guralnick 2001), concentrating on the following components:

- Screening program or referral
- Point of Access
- Comprehensive interagency assessment
- Development of programme plans
- Monitoring and outcome evaluations
- Transition

a. Screening programmes or referral into service use.

The recommendations underlying the screening and referral into programmes of early intervention of the DSMEI have been provided by Gilliam *et al.* (2005) and were set out earlier (p.89). The process is represented by the first component of 'screening programme or referral' (Figure 15).

Figure 15: Route into service use in the DSMEI.



adapted from Gurlanick 2005, p.17

The two pathways emerging from the screening and referral component of the DSMEI highlight differences between early intervention practices in the USA and Sure Start in the UK. In the USA special education and early intervention services are mandatory, and children qualify for intervention if they have delays in motor, communication, cognitive, social or self help skills, or have an environmental or biological problem likely to lead to delay. Sure Start in the UK differs in that the organisation targets services and activities more intensely at all families living in deprived areas. At first glance, this makes the section of the DSMEI showing the process for children screened but deemed to be ineligible for early intervention services irrelevant to the work of Sure Start, especially in RCTSS where all families and young children are eligible for services. However, the early part of the DSMEI which recommends differing levels of intervention - dependent upon the developmental progress and risk factors of children - turns attention back to the

concept of progressive universalism which, as pointed out earlier, is at the heart of Sure Start (Balls, 2006).

According to a Labour spokeman, progressive universalism aims to raise standards for all but provide more for those who need it most (Prescott, 2002). Such progressive universalism can/has been seen in the very existence of Sure Start and more latterly in Children's Centres. Recent government comment claims that this action is bringing increased resources to children and families in most need in England:

> *'I talked in 2005 about our belief in progressive universalism - providing support for all, with more support for those who need it most. That has always been our vision. And so in childcare, we've committed to universal support for all 3 and 4 year olds, because the evidence suggests that all children benefit from preschool. But we've also targeted our resources on those who need it most - through the Working Tax Credit, for example. Progressive universalism has always been at the heart of the concept of Sure Start Children's Centres. They already reach over a million children, and I can confirm today that we have now - by committing to increase spending on childcare, early years and Sure Start to £1.6 billion by 2010 to 2011, £340 million more than current levels - set aside the funding to meet our goal of 3,500 Children's Centres by 2010 - a national network, one in every community, serving nearly 3 million children.*
>
> *(Balls, 2006)*

However, this may not be a 'cure all', problems will still exist as many children who are living with or at increased risk of developmental problems may not be: aware of; in contact with; living in designated areas: willing or able to reach services such as Sure Start and associated Children's Centres. Despite the statement above, which implies that services will soon be within reach of all children in England, the government appears to recognise that it is not enough for these services/centres to be there waiting for parents to come to them, centres must reach out to families, particularly those families that need their services most (Balls, 2006). The difficulty of reaching people most likely to benefit from services was demonstrated well in the present study as three multi-risk families dropped out of service use early, whilst the other multi-risk families only took part in one service during the time of the study. So would a screening process as recommended in the DSMEI be of use for RCTSS, others SSLPs and/or in Children's Centres?

An official sounding 'screening process' does not fit well with the universal, voluntary, nature of Sure Start and Children Centres. However, the DSMEI is not that prescriptive,

its main purpose is to help communties and agencies examine their approaches and practices (Gurlanick, 2005). In relation to Sure Start, the screening component could be interpreted as an obligation to provide early, regular contact with families and children in their target areas, especially with those living in disadvantage. Regular contacts can then be used to: make all families aware of the range of services; encourage use of activities and facilities; and to ensure recognition of children and families needs when present, a recognition which can then trigger increased contact and service input if and when necessary. Using the screening or referral component of the DSMEI framework in this way promises to extend the universal progressive approach beyond the existence of the services/centres and into the way the services work. While excluding no individuals from service or centre use, this appraoch ensures regular contact and tailors the amount and intensity of service provision to the situation and circumstances of individual children and families.

When placing the experiences of study participants within the framework of the DSMEI, the specific recommendations for the screening component of the DSMEI state that the process should be early, periodic and focus ecologically on all areas affecting child development. The first point to be considered is whether RCTSS services are being offered early enough. It is appreciated that Sure Start service input begins during the ante-natal phase and some RCTSS services are offered before birth, but for reasons explained earlier (p.114) families receiving RCTSS services before birth have been excluded from this study. Amongst the study participants were children of a wide early age span (Table H), with four children/families referred by generic health visitors during the child's early months (three - six months old). This showed that early referrals to RCTSS are taking place. Whether such early referral is occurring universally is questionable based on the experiences of those participant families who were only referred to RCTSS when their child was two or older, and when the child's development (eating, sleeping, aggressive behaviour) had been of concern to their families for some time.

When looking at whether some screening or recognition of a family's needs was a periodic process it was found that further referrals to RCTSS took place over the first four years of life, some as the result of generic health visitor contact and some after contact with play group or statutory education providers. This provides evidence that

screening or consideration of a family's needs, with subsequent referral is occurring periodically as recommended by the DSMEI for some families. However questions arise about whether: these routine contacts are being made often enough to monitor effectively; assesses all factors that can impact on child development; and routinely results in referral to appropriate services such as Sure Start. It may be thought that in the UK – unlike the USA – contact and appraisal happens routinely as universal child development screening takes place through contacts and checks carried out by generic health visitors. In addition, for those in Sure Start areas, Sure Start recommends that contact is made with all eligible children in their areas and although programme guidance does not talk of screening, the remit is to make families aware of and to become continually involved with services.

When considering how well SSLP's are achieving regular contact with target families it was found that:

> *'..... an SSLP judged proficient by NESS established regular, consistent and growing reach for 100%,of all newborns but only 26 -50% of other targeted families. And only a small number of SSLP's achieved even this level of reach.'* *Anning & Ball 2007, p.108*

Within RCTSS, the findings of this study suggest they share difficulties in achieving regular, consistant reach to families and successful provision of services when necessary. One family - who had not used services when the child was referred at three months old - only came into contact with RCTSS again twenty two months later. By this time his areas of delay (as assessed by the ASQ and ASQ:SE) had increased from two to three areas, and during this time, apart from sporadically attending the baby clinic, the mother reported no contact with her generic health visitor or other activities or agencies. The developmental progression of another focus child, one who had been born prematurely, had deteriorated during the six months his mother saw the SS Counsellor, but the family was receiving no contact with their health visitor or other source of support for the child during this time. In addition, as considered in the above sections, the finding that many participants in this study had not heard of RCTSS before initial use, and were not aware of the role of the organisation in many local activities suggests RCTSS has not established regular, consistent contact with many eligible families. It also suggests that contact with generic health visitors often did not lead to knowledge and use of RCTSS, even though all families with children under four are 'target' families for RCTSS. This

discretion when referring children and families to intervention services does not appear to be limited to this study, as when considering whether screening leads to referral to early intervention services in the USA Gilliam *et al.* (2005) comment:

> *'at present there is a mandate that infants with conditions that place them at risk for developmental delay or disability must be provided early intervention services. States, however, are given great discretion as to which conditions trigger referral'*
>
> *Gilliam et al 2005, p.90*

This suggests that further work with organisations and agencies which refer to RCTSS services - to increase their knowledge of the work and relevance of Sure Start - may be needed. It again draws attention to the advantages of a routine visit of a Sure Start worker to every eligible family in their area to create a welcoming community based ethos, introduce the family to the services provided, and discuss the relevancy of the services to individual families. This dual approach – of generic and service providers – may also promote interagency working, enhance understanding of one another's roles and remits, and ensure all children and families who may profit from use of Sure Start services are offered the opportunity to become involved with them.

The final recommendation of the screening component of the DSMEI calls for ecological assessment of all factors which affect child development at the time of screening. Whether referral to RCTSS involves an ecological assessment of possible relevant developmental risk factors appears unlikely. Many participant families – especially the multi-risk families - were referred because of concerns about; child stimulation, maternal mental health problems and child communication delays, but other factors likely to affect child development co-existed. It was found that all but two of the referred families were referred to single services. In addition it was found that some problems i.e. child behaviour and eating and sleeping problems, had been identified by parents who then approached their generic health visitors/ GPs for help, which suggests that some problems are less likely to be picked up by health screening and/or routine contact with health staff. It was also interesting that few participant families had ever been asked about their perceived needs – for their children, as parents, as families and for their community.

Consideration of the recommendations of the DSMEI screening/referral component together with the experiences of study participants suggests that contact with target families and referral to RCTSS may be improved. The DSMEI suggests a a universal, periodic, systematic screening system, but for RCTSS, and perhaps wider SSLP's and Children's Centres, this could be interpreted in a way that meets the voluntary, universal approach of Sure Start. The recommendations underlying the screening and referral component ensure that regular contact is made with target families and children in RCT, and that agencies and individuals, including all RCTSS staff, who work with children and young families, are always aware of the need to assess needs and situations which may impact on or pose a risk to a child's development, and will therefore ensure contact with or referral to RCTSS.

b. Point of Access into service use.

When concern about a child's development reaches some criterion – including the concerns of parents – entry to the next component in the DSMEI a 'point of access (POA)' to the early intervention system occurs (Guralnick, 2005). The purpose of this component is to gain information from the family about the children's functioning and family concerns and to identify services the family would be available for, (further information about the recommendations underlying the POA (Harbin 2005) can be found on p.90). In RCTSS the point of access component appears to be blended into the referral process as entry into home visit interventions included referrers filling in a form describing the problem and a combined home visit of generic health visitors and Sure Start worker. However, it did not appear to lead to further systematic assessment of families needs. Harbin (2005) cites Bronfennbrenner (1979) when advising that among an interrelated set of values needed to accomplish the goals of a successful POA is the need for an ecological assessment of influential developmental factors in a child's environment.

The recommendations underlying an exemplary, integrated POA include the need for the point of access to be a welcoming friendly place, and state that the whole experience must be empowering with relationships built on recognition of family strengths (Harbin, 2005).This recommendation is supported by Melhuish *et al.* (2007) who advise that: the empowerment of Sure Start users and staff; the existence of good communications reflecting the characteristics of the community; a welcoming and inclusive ethos; and a

realistic and substantial involvement of families, are factors which contribute to the proficiency of SSLPs. The present study found that nearly all families who fully engaged in their service use talked of how they and the children had found the staff welcoming, and how they had enjoyed the service/activity. But most families who had used services to meet a need did not find that this positive experience led to further use of the RCTSS network, i.e. of further services and/or activities.

A number of the families who did not feel the service was enjoyable, had possessed initial reservations about contact with RCTSS staff and services. These were the families who had been referred to services and questioned the need for or point of services. Harbin comments that there is plenty of literature on the importance of empowering relationships, and the need for a trusting, caring relationship and for service providers to act as coaches to provide information and support to families must be recognised in a POA. Nevertheless, when contemplating using the DSMEI framework as a guide to the provision of early intervention services, this element appears somewhat lost in the component of 'point of access' with no component or discussion of the difficulties encountered when trying to empower families, or engaging 'hard to reach' families being apparent. As the issue of engaging multi-risk or hard to reach families is of relevance to the present study, and has been commented on by other researchers working with wider SSLPs, this subject will be discussed more fully later in this chapter.

The Point of Access component in the DSM also divides potential child service users into:

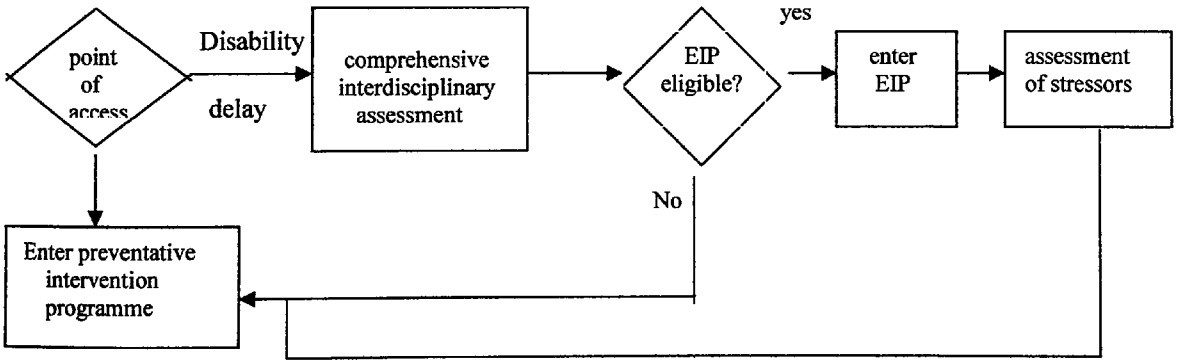
- Those with a particular problem but no delay or high risk of delays, for these it is recommended the presenting problem should be addressed
- Those not currently exhibiting delay but living with a designated level of biological/environmental risk factors, these are referred directly to a preventative programme
- Children with actual delay, suspicion of delay, or at very high risk of delay are referred for a comprehensive interdisciplinary assessment before entry into an intervention programme

Sure Start differs from early intervention services in the USA many of whose services are either preventative or to work on established delays and problems. Guralnick (2005) criticises the DSMEI for this distinction, but acknowledges that the practice in the USA of separating services for these different categories of children has led to this distinction. It can therefore be argued that Sure Start services, including those of RCTSS, better meets the principle of inclusion which overlies the DSMEI, as the provision of Sure Start universal services encourages the integration of services into the community and the inclusion of all potential service users from eligible areas.

c. Comprehensive interdisciplinary assessment (CIA).

When referred children demonstrate a disability/delay the DSMEI advocates use of a deeper, coordinated interdisciplinary assessment. This is central to the DSMEI and was conceived to allow professionals from different disciplines to work together, share information and skills, and so provide a comprehensive, more efficient assessment of need. The purpose of this is to avoid the provision of conflicting advice for parents, and to draw up a clear service framework which meets all identified needs and ensures coordinated service provision.

Figure 16: Assessment process in DSMEI .



EIP – early intervention programmeThe CIA must decide on eligibility for services, determine each child's condition, assess environmental threats, consider possible further impacts of child's condition and gain baseline information to assess the effectiveness of the interventions.

Some findings from recent NESS work (Melhuish *et al.* 2007) appear to support recommendations which underlie the CIA. These include that more effective SSLP's have:

- a strategy for the identification of users
- well established multi-agency teamwork
- clear pathways to access specialist services

In relation to this, Anning and Ball (2007) related the efficacy of SSLPs to the

> *'importance of identifying, diagnosing, and treating potential users of services in a systematic and cross agency way.'* *p.22*

This statement emphasises the importance of identifying and reaching potential users, and the vital role of systematic work which utilises services from multiple agencies to diagnose and 'treat' service users. In essence, this statement seems to endorse the framework and recommendations of the DSMEI up to the point of assessment and into the process of service provision.

In RCT all families with young children are eligible for RCTSS service use but the experiences of participant families suggest that after referral or entry into the programme there is little assessment of participant children's development, developmental environments or developmental risk factors either by the initial service provider or by an interagency team. It could be argued that collecting baseline data and carrying out assessment - a process advocated by the DSMEI – could be viewed as formal and stigmatising, and deter service use. But when working with vulnerable families, the full recognition of needs enables subsequent service provision to be capable of meeting these needs. If carried out sensitively, with full inclusion and consultation of parents, as recommended by Guralnick (2005), it is possible that assessment could be incorporated into RCTSS or wider SSLP service provision and contribute to better programme efficacy. If seeking guidance for the shape of an holistic assessment the DSMEI recommendations can be consulted as they itemise risk factors and stressors divided into: information needs, (Bailey & Powell, 2005); family characteristics (Kelly *et al.* 2005), resource needs (McWilliam, 2005) and interpersonal and family distress (Orsmond, 2005). The information is used to plan an individualised intervention programme for each child/family.

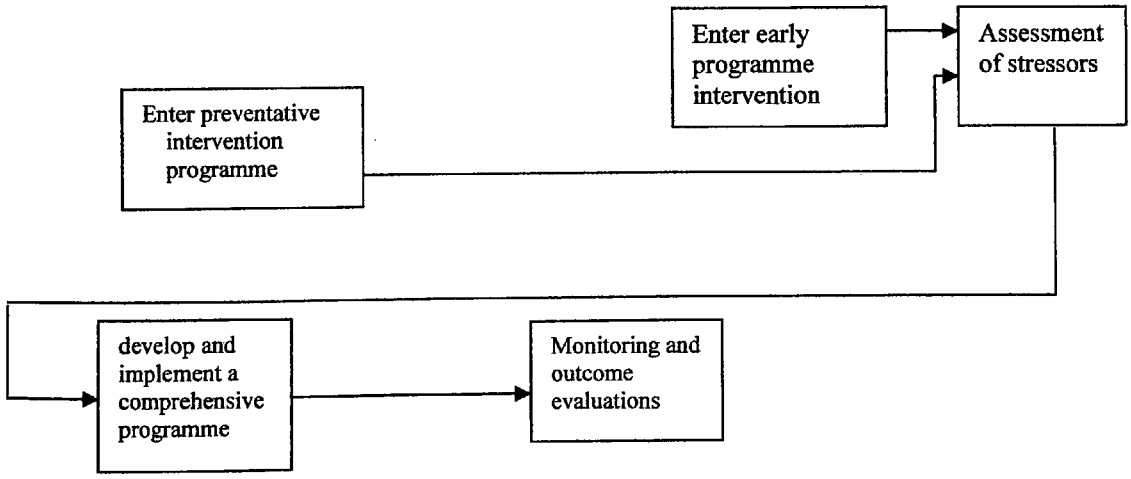
When considering multi-agency working in RCTSS, the evidence from this study suggests that multi-agency links and interventions could be improved as:

- During this study's recruitment phase many agencies would not discuss clients or become involved in the study because of confidentiality issues
- Few families used or were referred to more than one RCTSS service
- One RCTSS staff member remarked she did not know all the services offered by RCTSS, a comment which referred to present training practices
- Despite efforts by this researcher, little contact with and no referrals were received from Social Services staff who were RCTSS funded
- The problem of possible non referral of eligible families by generic health staff has been discussed earlier

d. Developing programme plans.

As shown in figure 17, the DSMEI links information gained from the assessment processes with the development of a comprehensive programme to meet these needs. Additionally the DSMEI's recommendations call for services to be provided in a way that fits family routines and maximises participation

Figure 17: Programme use and evaluation in the DSMEI:



As discussed above the experiences of this study's participants gave little evidence of multi-agency working, comprehensive assessments, and additionally there was no sign of programme plans. Exceptions are found in the narratives of two participants which show that their generic health visitor – who was the same individual for these two families -

appeared to assess the families' situation and refer to different RCTSS services to address the mental health needs of the mother as well the development and stimulation needs of the child. These two cases were the only ones for whom multiple referrals were made to meet differing needs. This can be compared to the experiences of two other mothers who were referred to meet mental health needs, but for whom no other services were suggested or used - even though the mothers both reported finding it difficult to play with or spend time with their children during the first data collection interview. Over the time of the study one of these children moved from developmental competence to non-competence between the first two study visits, but demonstrated competence a year later which was some time after his mother had finished seeing the counsellor and was reporting how much time she now spent with her son. Although the improvement in the child's competence may well have happened as a consequence of the improvement of the mother's mental health, it can be argued that assuming this sequence of events would take place may be over optimistic, and some work with the child to ensure continued developmental progress whilst the mother received help for her mental health concerns may be advisable. This possibility is illustrated by the child of the other mother who had moved from competence to non-competence by the final second visit. Although he may have followed a similar path as the child discussed above i.e. have improved developmentally by a third visit, this child had been born prematurely at a low birth weight and additionally by the time of the second visit the mother reported that marital difficulties were affecting the children's behaviours. This suggests additional support for the focus child's development may have been appropriate. No further study visits were possible as the family moved out of the area.

No further signs of any service plan - outside of the single services that participants were referred to - were found in the accounts of other participants, which suggests that at present RCTSS service programmes do not meet the recommendations of the DSMEI or of the NESS which found that proficient service delivery reflects guidance for core services in family support; health; play; early-learning and childcare with a balance focused on children, family and community.

Service provision must also be carried out in a way that fits in with family routines and maximises active family participation, (Guralnick, 2005). When considering how RCTSS services were provided, the large majority of study participants were happy with the way

services fitted in with their family routines. Where home visits were involved families reported pre-service contact from Sure Start staff to ensure timing was convenient. Three of the mothers attending counselling sessions reported difficulties in organising child care and getting to the hospitals where the service was based, and one mother said the timing of the SSCCW visits was difficult and an additional service she discovered herself had not been used because it coincided with her work hours. This suggests more consideration of barriers which may limit programme activity may further improve service provision i.e. providing child care, transport, and offering services in hours outside of parents work commitments, may have made use of some services easier. The problem of making families active in service use arose with many of the multi-risk families, some of whom withdrew from services, some who did not become involved in the service sessions, and one who only took part when offered a service which met her priorities. Again this calls for consideration of ways to engage families who have no active wish or desire for services.

f. Monitoring and outcome evaluations:

Figure 17 in the above section shows the DSMEI demands monitoring and outcome evaluation of the programme effects on an individual level. Warfield and Hauser- Cram (2005) describe how monitoring and evaluation should be matched to the goal of programmes i.e. to discover if the programme meets the developmental needs of children and their families.

On the basis of the experiences of participant families in the present study and the findings of earlier evaluations of RCTSS, it appears little systematic evaluation of service impact or outcome is taking place within RCTSS on a programme or individual level. Evidence that some evaluation was taking place was found in the following instances:

- RCTSS Health visitors and Child Care workers would offer additional sessions if they felt it was appropriate, and would encourage participants to contact them if concerned.
- Counsellors would offer additional services if participants felt they needed them
- On service completion one participant was referred to a further RCTSS service. This was a family with a Down's child, and the mother reported the further

referral took place because both her health visitor and her SSCCW felt she needed long term support.

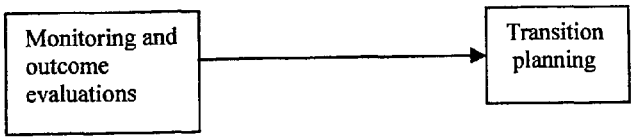
- One child developed sleeping problems and was referred to a SSHV, whilst seeing a SSCCW.

Despite these positive findings, many participant children, including all the multi-risk children were discharged from service use with developmental delays and unrecognised developmental risk factors. This suggests that the recommendations underlying the evaluation and monitoring component of the DSMEI may, if adopted by RCTSS help service provision become more effective. To meet their recommendations Warfield and Hauser-Cram (2005) call for evaluation of all aspects of the services which impact on the development of children, i.e. consideration of how well services are assessing and recognising service users needs; the adequacy of available services to address identified needs; the quality of services and the perceived (as opposed to the objective) effects of interventions. In addition objective assessments of the outcome of the programme's intended effects, i.e. changes in children's development, environments and experiences, could be performed.

g. Transition planning.

Transition is a time of change and the complex process of transition is included in the DSM (figure 18)

Figure 18: Transition to other services or leaving of programme in the DSM:



Hanson (2005) analyses four major components which affect the process of transition; personal characteristics and experiences: the communication and interaction skills of all people involved in early years services; and the personalities, goals and expectations of service users and providers; the relationships between participants; procedural variables; the amount and type of support: it is also recommended that support should be flexible as needs vary between individuals (p.102).

The procedures of programmes affect transition. Transition policy is integral in the USA, with a written plan and co-ordinated activities to support transition stipulated at age 3 for eligible children. No such policy exists with Sure Start, a programme in which participation is voluntary even when a child is eligible for service use. The voluntary nature of Sure Start service use, and the lack of interagency working and referral to further services, found in the experiences of this study's participants made it impossible to compare transitional procedures as recommended in the DSMEI with those practiced by RCTSS. However other SSLPs have encouraged transition to other services by, signposting and providing additional opportunities in successive stages from antenatal services to a child's entrance to pre-school. Maintaining service usage was associated with systems such as:

> *'....a natural progression through pregnancy, childbirth and subsequent childhood developmental stages. Parents were signposted during pregnancy through an overstretched mainstream hospital antenatal service, to the programmes course of antenatal classes. As the course came to an end, parents were given a tour of the children's centre building, introduced to staff, and given information on breastfeeding groups and the baby club. Parents then felt comfortable about returning to the centre with their new born child. As their child grew, they were signposted to weaning parties, library services, cooking for toddlers, toddler gym, stay and play groups, nursery and playschool.'*
>
> *Anning et al. 2007,p.66*

Although evidence of similar processes was not found among the experiences of study participants, it is possible a similar system may be running in the Glyncoch family centre as the centre offers services from RCTSS, and runs parent groups, mother and toddler and child care groups, and organises outings. Some evidence of the value of good transitional processes was given by one participant mother who was a primary school teacher in a school served by the Sure Start mother and toddler group/play group, and whose child attended these groups throughout the study. She spoke of the quality of the groups, the good conduct and skills of children who had attended them and of the ease with which the children made the transition to the primary school with visits and regular contact. Early study visits to primary schools based in Penywaun and Glyncoch, two extremely deprived areas which also contained the two original family centres - suggested good relationships and transitional processes existed between schools and the centres in these areas. Unfortunately the study failed to recruit participants from these areas an occurrence which prevented knowledge about family experiences of the transitional processes. This does suggest successive service provision promotes continual

engagement of families, and again highlights the value of a community centre to house the services. Whatever the experiences of families using the available centres in RCTSS, the current situation still leaves many families far away from centres and activities which mediate continual engagement and service use. This leaves unanswered questions about the ability of RCTSS to provide an appropriate network of services over such a wide geographical area.

h. Summary.

In the above section participants' experiences with RCTSS were set within the DSMEI. This exercise allowed comparison of the early interventional services as provided by RCTSS with the process as detailed by Guralnick (2001, 2005) and identified areas where RCTSS practice differs from the recommendations and process of the DSMEI. The setting of RCTSS services - as illustrated by the experiences of this study's participant families - in the DSMEI, suggested that one area of service provision i.e. the need to engage vulnerable families in use of early intervention programmes, may need more clarification within the DSMEI especially when, as with Sure Start, programme participation is purely voluntary.

7.7. Adding to the Developmental Systems Model.

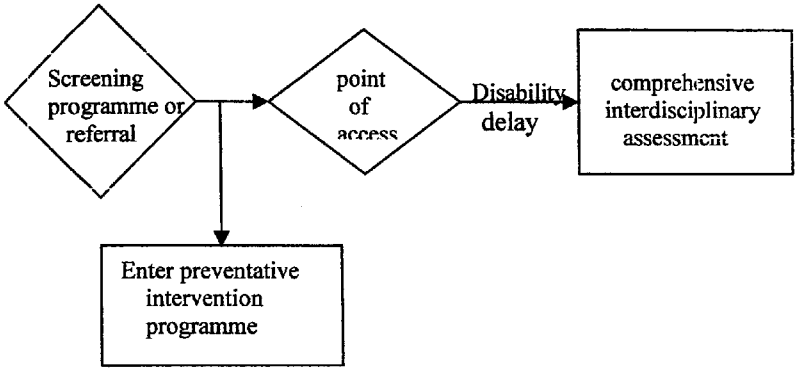
The DSMEI is a coherent theoretical model which gives a framework for early intervention programmes, setting them in a developmental context within the core principles of inclusion and integration. The section above set the process of RCTSS service use within the DSMEI framework. During this process it became apparent that although many of the studies' multi-risk families failed to fully engage in service use, the DSMEI includes no component to explicitly address the problem of non engagement of vulnerable families, a problem encountered widely throughout the field of early intervention programmes (e.g. Fonagy 1998; Barnes & Freude- Lagevadi, 2003). This is an important problem:

> *'the engagement of parents is an essential precondition for the success of a program, even if this is focused principally upon children'*
>
> *Fonagy, 1998, p.130*

Family interventions work best when the child and family want to be involved and want the intervention to work (Buchanan, 2002) and view the services as meaningful

(Bremberg, 2006). The problem of engaging 'hard to reach' families brings attention to the area of the DSMEI between the initial screening/referral to service use and entry into a preventative intervention programme or into a CIA. In Sure Start this would be between referral to services and users first contact with service providers (figure 19).

Figure 19: Programme referral to entry into service use in the DSMEI.



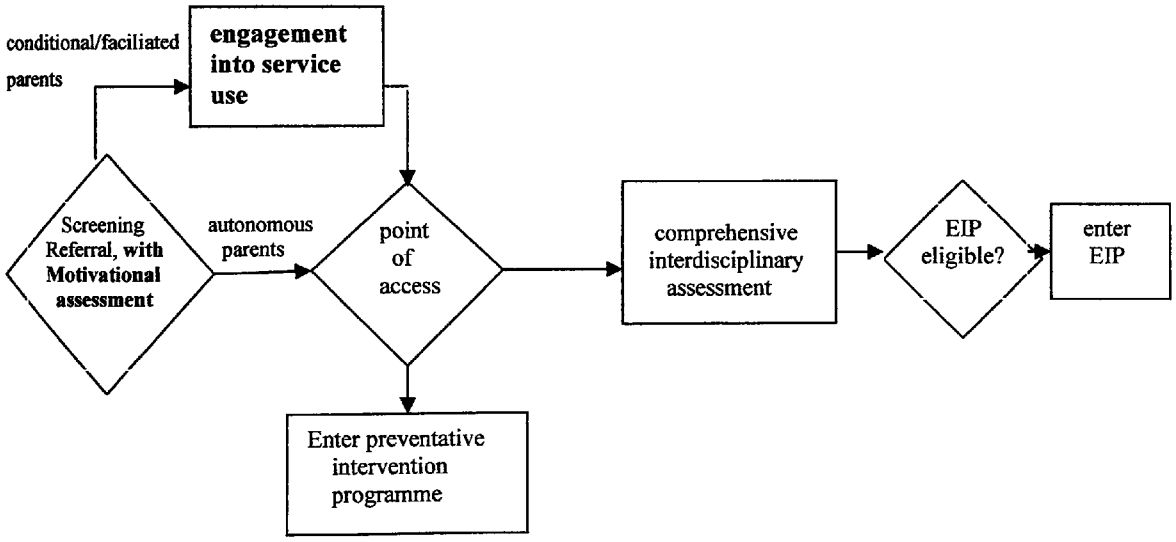
Participants in the present study cited many barriers to service use (p. 199, 203). Barlow *et al.* (2005) identified concerns about; homes being judged: establishing relationships outside family and friend networks; individuals feeling they are not in need; decisions that the intervention is not applicable; parents feeling they are treated in a manner that suggests they are not competent; and the nature of the relationship between the home visitor and the parent, as barriers to service engagement. It has also been found that the type of services offered affects service use, with vulnerable families most likely to maintain attendance if services included discussion of concerns such as health problems and personal worries as well as child management difficulties (Barnes & Freude-Lagevardi, 2003; Statham, 2004). This all suggests that the time between referral to a programme and programme use is a period when potential service users - especially those who have been referred to services rather than have chosen to or have asked to become involved - may benefit from some assessment of their attitudes to and motivations for service use. When discussing the work of SSLPs, Tunstill and Allnock (2007) appreciate that not all parents wish to engage with service in an identical manner, and identified three parental styles of service use as existing, styles which can be identified in this study's participant parents:

- Autonomous parents: who on learning of services visited the programme of their own accord

- Facilitated parents: who may initially be reluctant to use services and needed encouragement to use them, but after assistance will use the programme
- Conditional parents: for whom any encouragement was inadequate

This initial informal categorisation during early contacts with families could be followed either by direct entry into the next stage of the programme, or if attitudes and motivations for service use are poor into an early additional phase to positively affect feelings about and motivation for service use, i.e. to work towards a better relationship between service users and providers and a more positive attitude to service use. This work may better engage families and consequently lead to more sustained and active service use. Figure 20 shows the first section of service provision in the DSMEI with these components added;

Figure 20: Revised entry into service use in the DSMEI .



When considering what form this additional stage may take, it is important to remember that families initiating service use are entering a period of change or transition. As outlined earlier Hanson (2005) proposes major components affect transitions and influence family acceptance of associated changes. When considering service use these may include:

- the goals and expectations of the families and children e.g. the priorities of participants (Barlow, 2005), their attitudes (Barlow, 2005) and the meaningfulness of the intervention (Bremberg, 2006)
- the relationships between participants, creating good relationships with families can increase the participation of even 'hard to reach families' (Weinberger, 2003; Howarth & Foreman, 2006), and even infrequent contact over a short period of time may be the prelude to more sustained contact, (Barlow, 2005)
- the amount and type of support needed by different families, as was illustrated in the present study when one mother refused earlier referrals to Sure Start as they did not give her the support she wished for and another mother whose family commitments meant she felt she had no time for service at the time it was offered and the service was withdrawn

Research cited earlier (e.g. Simpson, 2002) has already suggested that time spent engaging vulnerable families, can reap rewards as it increases the service participation of potential vulnerable service users. Research has also shown that parents can be motivated to some changes of behaviour that positively affect their children (Weinstein *et al.* 2004, Ondersma *et al.* 2007). It is therefore argued that while the actual form of interaction needed to best promote the engagement of some families in services needs further research, some assessment of a family's motivation for and attitude to service use when it is first suggested, followed by a component of service engagement for families who appear reluctant to begin services may augment the DSMEI's ability to guide early intervention service provision. This may then be used to help service programmes and providers to more fully engage with and meet the needs of families who may benefit from an interventional programme but are wary of becoming involved in initial service use.

7.8. Limitations of the study.

This study faced many challenges during its design and recruitment phases, these will be discussed in this section.

Firstly, despite gaining ethical approval from COREC and from the Research and development offices of the relevent Health Authorities providing services to RCT, an omission in the information and consent procedures has been identified. The data collection home visits included use of the ASQ, ASQ:SE and HOME assessments.

Althought the study information sheets (Appendix G), told parents the type of information the study sought and that it was interested in the development of children associated with services, it did not specify that there would be an assessment of the home environment. Again, during the actual visits parents were told that the study was interested in their child's typical day, but it was not made clear that this information would be used to assess the developmental environment of the child. This lack of clarity was unfortunate and unethical, and would of course be avoided in any future work. It is also appreciated that this omission may have affected the actual data collected as, if parents been aware that their home environments would be evaluated this may have altered the information given, as parents may have been more guarded and/or less open and honest.

The focus in this study has been on findings drawn from the experiences of participant families and on the associated developmental changes perceived by parents. However, in order to gain additional measures of whether developmental changes took place during the time of service use, quantitative assessments of the focus children's development and their developmental environment were also collected. The resources of the present study limited the developmental assessment tools available for consideration, which resulted in use of the ASQ and the ASQ:SE (Squires *et al.* 1999, 2003). These measures proved useful tools for performing successive developmental assessments as they were found to be quick, rapid and cheap. In addition they covered all relevant developmental areas, and were inclusive as they use parental opinion, and could promote integration as it could be used and easily understood by staff from multiple agencies. These findings suggest the ASQ & ASQ:SE could be extensively used for rapid assessment and the monitoring of child development in programmes such as Sure Start. This may provide a solution to problems of assessment found during the present study, as the management of generic health visitors felt generic health visitors lacked the time to track the developmental progression of the study's focus children and were reluctant to endorse use of some assessments by other workers such as SSCCW's as they felt these Sure Start staff members were not qualified to perform such assessments. Systematic use of ASQ and ASQSE, for use on an individual level for all children using SSLP's to counter problems and delays, and/or who are deemed to be at risk of developmental delay appears sensible, feasible and available for use by all staff involved.

On a less positive note, the unexpectedly low number of participants in the study sample meant ASQ and ASQ:SE were only able to indicate whether focus children were developmentally competent or non-competent when assessed, but could not be analysed for statistical differences in developmental areas. A larger study with increased sample size and cohorts of children who began service use at the same age, or were assessed at the same age such as in the NESS, would have allowed statistical analysis to be performed and so identify significant developmental changes in the participant sample. Although it could be argued a wider sample would just be repeating the work of the NESS, this procedure may have provided valuable information as the focus children in this study were all associated with Sure Start services, unlike the sample in the NESS who were children living in Sure Start areas. If the developmental progression of a wider sample who had used Sure Start services could be compared with control groups - such as the Millennium Cohort Study children used in the second phase of the impact study of NESS (2008) this could provide useful information. In relation to this study, the quantitative assessments gained would have been strengthened by use of a control group, but as discussed earlier (4.5.b.), the practices of many Sure Start local programmes in South Wales made formation and use of a control group impossible, and with the numbers of participants involved, and the focus on the qualitative element in this study, a control group would have been of limited use.

The knowledge that a larger sample size may have benefited this research turns attention to how representative the services and participants involved in this study are. The study recruitment criteria excluded mothers using RCTSS antenatal services and children whose families had had previous contact with RCTSS, and discussions found that RCTSS staff felt this excluded a large proportion of service users, although the inadequate data currently collected by RCTSS about new service users made exploration of this issue impossible. The problem of recruiting families drew attention to factors such as: the strength of interagency bonds within RCTSS, the involvement of some agencies associated with RCT, and the type of families who became involved in services and/or the study. However the point of the study was to explore service user's experiences and perceptions of service use, and it is argued that the participant families recruited to this study were typical of the families using the RCTSS services involved. In a study which was mainly qualitative in nature, a larger study sample would have been difficult to manage over the given time period without increased time and staff resources. This

study's findings that parental perceptions of service effects on their children's development were largely supported by the developmental assessments, and that some perceived effects of service use would not have been identified by developmental measures, calls for extension of the qualitative element of this study to a larger sample of service users and or RCTSS agencies.

As mentioned above, during meetings in the recruitment phase of this study some services were found to be reluctant to become involved due to the confidentiality practices of their agency, or due to concerns that service users may react by withdrawing from service use completely. This barrier may have been overcome by use of participatory research in which people involved in the service became researchers. Recruitment numbers also appeared limited by the resources of the services themselves, one family centre reported they were 'full' and had no new service users over the time of the study, while the Assisted Places scheme had limited funding and could only offer services to a limited number of families. These problems meant that some services were not represented in the present study, although fortunately the study participants used many RCTSS 'core services.'

The majority of participants lived in the South West section of RCT, or near the corridor formed by major roadways between Treforest in the South, Abercynon further north and Aberdare, to the west. Few participants lived in areas in the north-west of RCT. Whether this reflects the inability of RCTSS to engage families in these areas, or low referral of potential participants by service providers is unknown. But other agencies e.g.'On Track,' and some schools with large community education and activity profiles exist in some of these areas, a situation which may mean less families in these areas are aware of or referred to RCTSS services. What ever the reason, the lack of participants from across all of RCT is a limitation of this study.

In many parts of the UK it could be argued that the low numbers of families from non-Caucasion ethnicities made the participant families non-representative of their community population. However in RCT 93.3% of the population were born in Wales, (2001 Census, ONS), therefore the inclusion of two families with origins in Asian or Caribbean cultures does not appear to be non-representative. When considering gender, every data collection phase was held with the mother and/or grandmother as the main contributor, although fathers were present in two families. With one quarter of participant

families headed by a single mother, and twenty five families headed by couples in which the male head of house was employed in full time work, it can be argued that the mother was the individual who provided and/or probably had greatest knowledge of the child's developmental environment. On reflection, more contributions from fathers would have been welcomed and may have extended knowledge of the child's daily experiences by describing activities they did together. In further studies paternal consultation could be encouraged by data collections taking place in the evenings and weekends.

7.9. Conclusion

This chapter began by outlining the background, rationale and methods of the present study, continued with a discussion of the study's findings in relation to Guralnick's DSMEI (2001), and the suggestion that an additional stage in the DSM may help direct work to engage the more hard to reach families. The chapter finished with a consideration of the study's limitations.

The final chapter will summarise the present study, and make some recommendations for changes to RCTSS which may increase the programmes efficacy.

CHAPTER EIGHT: Conclusion.

8.1. Introduction.

Embedded within the relatively recent surge of interest, research and knowledge in the field of child development are areas of current interest in the UK, namely the development of children growing up in deprivation and/or poverty and how to provide these children with a better start in life. Sure Start is an early intervention programme formed to promote the development of children living in deprived areas, which has been operating in the UK since 1999. This study was based on a Sure Start Local Programme which has been working since 2000 throughout Rhondda Cynon Taff (RCTSS), one of the most disadvantaged areas of Wales. This study explored the experiences of families using RCTSS services to discover whether the agency was adequately reaching the more disadvantaged children in RCT, and whether service use led to the recognition and meeting of the needs of services users. The effects of Sure Start services on participant children and families were investigated, with the DSMEI used to provide practical information to enhance the services offered by RCTSS. This final chapter will reflect on how well the studies findings met the objectives set out above, before continuing to consider how this study has contributed to current knowledge. Some recommendations for changes in the way RCTSS provided are also made.

8.2. Meeting the Study's Objectives.

RCT is an area of widespread disadvantage, and this study met limited success when trying to discover how well RCTSS services are reaching eligible families especially disadvantaged ones. Even after acknowledging concerns of RCTSS staff about recruitment criteria, the limitations imposed by: delays in gaining ethical approval; services feeling unable to become involved in the study; the absence of universal, systematic, interagency processes to direct and record the screening, low referral/ service use of families, all contributed to the unexpectedly low numbers of families recruited to this study over a time span of six months. Related recommendations concerning interagency links and the screening/referral of families will be addressed later.

This study identified many barriers to use of services by deprived families which supported those identified by evaluations performed for wider SSLPs. This confirms it is vitally important for RCTSS and other SSLPs to strive to find and use methods to reach 'hard to reach' families, and to attract them to and keep them in services. This goal is

undoubtedly a challenge but one which can, as considered in section 7.2, be achieved by use of various strategies.

In RCT many barriers cited by service users, e.g. lack of awareness of services, little knowledge of what service use entails, and transport problems, supports the provision of services and activities for families and young children through centres that are close to home and easily accessible. This would obviously be helped by the provision of more children's centres throughout the county. Recent conversation with Sure Start programme managers suggests the formation of satellite centres attached to local schools is being considered. If this comes about it may bring RCTSS and associated services more firmly into additional communities. As illustrated by the popularity of the services in one family centre in a deprived area of RCT, this could lead to better awareness of and sustained use of family services, as well as providing a bridge into statutory education thus easing this transitional process.

This study also aimed to discover whether use of RCTSS services led to the recognition of all the needs of service users, and this aim was achieved. When lower-risk participant families had one or two needs, problems or difficulties, these were often recognised - by the family or by generic health/education staff - and referral or use of Sure Start services was made to address these needs. However the extent of the needs of other families remained largely unrecognised. This was particularly apparent in the accounts of multi-risk families who were living with varied, enduring, and complex needs before, during and after service use. These experiences suggest RCTSS service use does not always lead to recognition of all family's relevant needs, especially if the needs are complex or numerous, however the small sample size achieved in this study calls for future research to discover if this practice is found more widely.

Collectively, the exploration of the perceived effects of RCTSS services on children's development supported those of earlier evaluations of EHS and the earlier NESS findings (2005a), i.e. that the impact and effects of service use can be described as mixed, and is related to the pre-service situation of service users. Many focus children who used universal services were developing well before, during and after service use, and no particular positive effect was noted. Findings drawn from families using services to meet identified needs concur with findings that interventions, particularly instances of inter-

actional parental guidance are less effective with the children of young vulnerable mothers than with lower-risk families (Love *et al.* 2005; Belsky & Melhuish, 2007). Lower risk participant families who used services to meet single needs often felt service use had helped resolve this need by improving their interaction with the focus child. Other participant's experiences - including those of all the multi-needs families who engaged in service use - suggested that services may have had some positive impact but that problems still existed after service use ceased.

When considering whether RCTSS service use met service user's needs, it was found that when families used services to address single needs, service use usually resolved the presenting problem, and since these families did not appear to have to other developmentally related problems, it can be claimed that use of RCTSS met all the needs of these families. However for other - mainly multi-risk - families the lack of awareness or recognition of all existing needs left service providers unaware of and hence unable to address some needs at all, let alone address family needs in combination, an approach recommended to adequately address a child's developmental needs (Sameroff, 1998), and supported by the finding of the NESS that within families with very young children services which address the needs of both parents and children concurrently are likely to be successful (Anning *et al.* 2007). All participant multi-risk families left service use after completing initial service despite enduring or new concerns and developmental delays. This strongly suggests that RCTSS service use does not always fully meet the needs of families, especially those with complex multiple needs.

The above findings suggest that regular contact with target families should be ensured. Regular contact, which is made routinely by generic health visitors and should be made by the staff of RCTSS in the course of service provision, could be used to form relationships with families, to make them aware of all the RCTSS services and to recognise developmentally related family needs. This is important, especially in areas such as RCT where RCTSS is not an important focus or part of the community. This in turn could lead to the provision of further appropriate services to meet all needs. The finding that families left service use with existing concerns and instances of child developmental delays also calls for better evaluation of the effects of interventions and the ongoing progress and needs of families and focus children. A more systematic framework for RCTSS service provision which includes elements of screening,

assessment, service provision, evaluation and monitoring during early intervention programmes may be needed to increase the effectiveness of early intervention programmes, and this turns attention to the use of existing models of early intervention such as the DSMEI.

8.3. Setting RCTSS services within the framework of DSMEI.

This study set the work of RCTSS - as experienced by participant families and children - within Guralnick's DSMEI. The intent was to set participant's experiences within the process of service provision as presented in the DSMEI and consult the model's underlying recommendations to seek for changes which may improve the efficacy of RCTSS. This exercise proved valuable, as it allowed service provision to be examined in a systematic way, and highlighted the areas of: screening and referral; assessment; service provision and monitoring and evaluation, as being areas where RCTSS may improve their service effectiveness by moving further towards evidence based practice as itemised in many of the recommendations of the DSMEI. Recommendations of how the practices of RCTSS could be changed can be found below.

The experiences of this study's participants were also used to consider whether the DSMEI could be changed in any way to augments its ability to assess and meet participant's needs and situations. The experiences of the multi-risk families, together with further available literature about the problem of engaging hard to reach or multi-risk families in early interventional programmes, identified this as an area of current concern. As involvement in early intervention programmes is often purely voluntary, further work to engage families in services such as Sure Start is called for. The DSMEI gives a framework for early interventional programmes when working with children at risk of or exhibiting disabilities or developmental delays, but fails to incorporate any assessment of families attitudes or motivation for service use at the time of referral, and may benefit from a separate component which seeks to better engage those families who appear reluctant or disinterested in service use. It is therefore proposed that the addition of these elements to the DSMEI may increase the efficacy of early interventional programmes when working with families, particularly 'hard to reach' families. At present, the Mental Health Foundation is funding a project 'The Promoting Engagement Project' whose aim is to increase understanding of this issue and so help address this problem (Cornah, 2002). Emerging findings from studies such this can be used in further research to

explore the best ways to engage with 'hard to reach' families in service use, enable them to become more involved in the services, and results in greater positive impacts on the development of their children.

8:4. Recommendations.

The following recommendations for RCTSS are based on the findings of this study.

- That further effort is made to improve awareness and knowledge of Sure Start services for potential service users, and for the staff of other agencies who work with families and young children within RCT
- More Children's Centres are established within RCT, to provide a local focus for community life, services and activities including RCTSS. This promises to promote knowledge of RCTSS and encourage transition to and use of other services
- Regular contact with families is ensured. Staff should be aware of the family situation, the child's progress, use contacts to build relationships with families, and be ready to respond to any changes in their needs or concerns. This is especially important when families are living with multiple developmental risk factors. Consideration of referral to RCTSS should always be included when delays or problems are identified
- The experiences of the 'multi-risk' families referred to Sure Start services, suggests these families are less likely than lower-risk families to fully use services, and if they do to engage less well. Further work at the point of referral to engage these families is recommended, as this may increase the probability of multi-risk families using and engaging in the services
- A number of families held complex needs and problems which did not appear to be recognised. The recommendation is that when indicated a child with, or at increased risk of a developmental delay is referred to Sure Start, a comprehensive, interdisciplinary, family based assessment is sensitively carried out. This may help to ensure all relevant concerns and problems of the child or the family unit are recognised, and give the agency a better chance to address all relevant concerns through interagency working
- Service plans are formulated through consultation of the families and of staff from all agencies who are involved in the plan

- Many less disadvantaged children used services to address one area of concern or delay. These children responded well, and the majority were discharged from services with no remaining developmental concerns. But some of these children, together with all children in 'multi-needs' families left services with remaining delay(s) or problem(s). The recommendation is that family centred 'post-service use' reviews and evaluations are used to ensure service provision addresses all needs and is maintained as long as necessary to make a real difference
- It is recommended that a Sure Start data base is set up. This would need family permission for inclusion in the database – but would allow better knowledge about the extent of services use by families and young children in RCT, the tracking of service use by individual families, and the keeping of records of the developmental progress and situation of children and families involved with RCTSS. Such data may help facilitate service treatment planning for children and families using Sure Start, and ease the evaluation of the use and effects of individual services and individual children. A database could also improve communication between the different agencies involved in Sure Start and avoid duplication of services, and better communication with families which may help to keep them aware of what is available in their area.
- Increased resources are provided to allow services which are fully used to be expanded and become available to more children and families, and to allow services to be taken more widely into all areas of the community, become better known, and alleviate transport problems, and thereby increase the number of families and children existing services can work with

8.5. Contributions to knowledge.

This study has contributed to knowledge about the service provision and evaluation of SSLPs, by investigating the process and effects of service use of a Welsh Local Sure Start programme, a programme in a devolved country not part of the NESS. Many of the study's findings confirmed that of other early intervention programmes, (e.g. EHS, NESS 2005a) i.e. that the services are valued, enjoyed and are having positive effect on many children from less disadvantaged families, but also that they are not always associated with enough contact and effect on the developmental progress of children with multiple risk problems and needs.

In relation to the evaluation of SSLPs, the use of ASQ and ASQ:SE assessments to determine the developmental progress of participant children during their association with RCTSS, suggested that these assessments could play a useful role in future evaluations of early intervention schemes and programmes. It was found that the ASQ and ASQ:SE assessments required little training before implementation, proved easy to score and analyse, and provided a quick, standardised method of assessment. This suggests that these assessment tools could play a useful role in the evaluation and monitoring of children in or at risk of delay, as – in addition – they were measures that could be easily understood and used by parents and by staff from different agencies. Many developmental assessments (e.g. Schedule of Growing, Bayley, Griffiths) need trained professional staff to conduct them, and – as found in this study – this can limit their use. This calls for further research to explore its possible role in early intervention services within the UK, as it could extend evaluation of the effects of services to many more children, in a way that may promote interagency communication.

Use of narrative as a qualitative method produced rich descriptive accounts of family lives and of their experiences of RCTSS service use in the large majority of cases. This data may not have been collected by use of questionnaires, structured or even semi-structured interviews. The comment of one grandmother encapsulated this as she asked her daughter:

> *'...have you told A. about the counsellor visits, they were awful,'*

This, and similar comments from other service users, implies that family members felt able to talk to the researcher(s), and suggests that use of objective evaluators to collect data encouraged realistic reports of service use. Whilst many mothers were often full of praise for the services, some were also confident enough to criticise the services when they felt necessary. Whether families would have been as critical if the service providers had been collecting data is questionable.

In contrast to many other SSLPs, RCTSS have been providing services on a wide, county area. This practice allowed the study to explore the provision of Sure Start services on a wide geographical base. It was found that although services were available throughout the county, use of services appeared limited by lack of awareness or knowledge about

services, by the limited financial resources of some services, and by transport problems which arose when services were beyond walking distance for potential service users. Many of these problems have been cited by other evaluations but in RCT may be more of an issue because of the wide remit of resources over the whole area of RCT. The finding that few family, and more recently Children's Centres, existed in RCT meant many families in wider areas of RCT were far from a children's centre which can provide a hub for related children's services. This strongly supports the Sure Start recommendation of providing services through centres which are within easy reach of family homes.

The application of the DSMEI to the services of a SSLP has not been found in any other available literature. This exercise has contributed to knowledge as it proved useful in the evaluation of the working practices of a SSLP. It helped identify areas where current practices are not meeting those believed to be effective in early intervention practices. Resultant recommendations are itemised above but in summary RCTSS service procedure may become more efficient by adhering more closely to evidence based recommendations as illustrated by models of early intervention such as the DSMEI. The models could also be used as a point of reference for individuals working in the field of early intervention, promote interagency communication, and ensure all contributory services share the same values, aims and goals.

The insight gained by applying the DSMEI to the work of RCTSS supports the claim of Guralnick (2005) – that the DSMEI can be used as a catalyst for communities, clusters of communities, and national organisations to examine their practices and improve the system of early interventional services. For RCTSS the model was a useful evaluative tool and could be further used to change and direct service provision, increase efficacy and improve early intervention programmes. Further work to discover whether the model could be profitably used as a framework to study and enhance the work of other SSLP's and other early interventional work may be worthwhile.

The efficacy of early interventional programmes is dependent upon whether children and families become actively engaged in the services. Current knowledge of the problem of engaging 'hard to reach' families in early interventional programmes, alongside the experiences of multi-risk participant families in this study suggests that the DSMEI may be improved by the addition of some assessment of family's attitude to and motivation for service use at the point of referral. Where deemed necessary this would lead to a

period of engagement and motivation for families before service use is planned and begun. It has been found that 'hard to reach' families will use services but it may take intensive time and input to engage them (Weinberger, 2003; Howarth & Foreman, 2006).

8.6. Concluding remarks.

RCTSS provides and coordinates early intervention services for families with young children across the entire county of Rhondda Cynon Taff and shares the aims of the national Sure Start programme namely, to reach families in their areas and have a positive effect on the development of children living in deprived areas. Despite being unable to fully inform about the reach of RCTSS, the experiences of the participant families indicated that the services provided by RCTSS are often capable of addressing the needs of families living with few developmental risk factors, and can be associated with positive impacts on the development of these families' children. However, the study also found RCTSS services to be less effective when working with participant multi-risk families who were more likely to withdraw from or not engage well in services, and who left service use with ongoing child and family concerns.

The provision of services over the whole county of RCT did not appear to promote universal county-wide knowledge of the services available, especially in areas which were not served by a family centre. Participant accounts of their experiences with RCTSS suggested the agency did not have a strong local identity for many participant families, many of whom - for reasons discussed in the thesis above – limited their contact with RCTSS to their initial episode of service use. These findings appear to support use of local central bases for services, in order to improve knowledge of and access to child and family services, especially when aimed at deprived communities who can find accessing facilities beyond walking distance difficult.

This study found that RCTSS shares some of the challenges faced by wider SSLPs, i.e. to ensure they provide their services in the most effective way possible. Gurlanick's DSMEI provides a framework for a systematic effective procedure of early intervention to promote child development. This study suggests the DSMEI is relevant for Sure Start Local Programmes, as while ensuring autonomy in decisions about which services are offered and sharing the ecological perspective and the integration and inclusion ethos endorsed by Sure Start principles and by NESS findings, it can be used – as illustrated by this study - to guide the whole process and evaluation the early intervention services

provided by SSLP's. Ultimately this may result in services having a greater impact on families and become more effective in promoting child development .

Further fmdings of this study concurred with results from other early intervention evaluations – such as those recently published by the NESS - that multi-risk or 'hard to reach' families can be difficult to reach and to engage in service use. This is an important problem as, while recognizing the hoped for 'ripple effect' achieved by improving communities, the effect of intervention programmes is limited if families and children do not take part. It has therefore been suggested that the DSMEI be supplemented by an assessment of family attitudes and motivation for service use or involvement at the point of referral in order to identify those families who appear reluctant to use services. Once identified such families could enter a phase of engagement and/or motivation before further service use began, thus increasing the likelihood that those families and children most in need of help would use, remain and profit from the activities and intervention services.

The experiences of the children and families who became involved in this study suggests that RCTSS has the capability of impacting positively on the development of young children in their area, but that some expansion of services into the community together with a more systematic procedure of service provision and a focus on engaging the vulnerable families is needed to help services reach those most in need. The recommended changes discussed above, may better ensure that: all target families are reached; the needs of service users are recognized; services are provided to meet all needs; the effect of service use is evaluated and monitored, this may help services to become more effective. Such action may help Sure Start move closer to its overall aim: to promote the development of the most vulnerable children in the UK.

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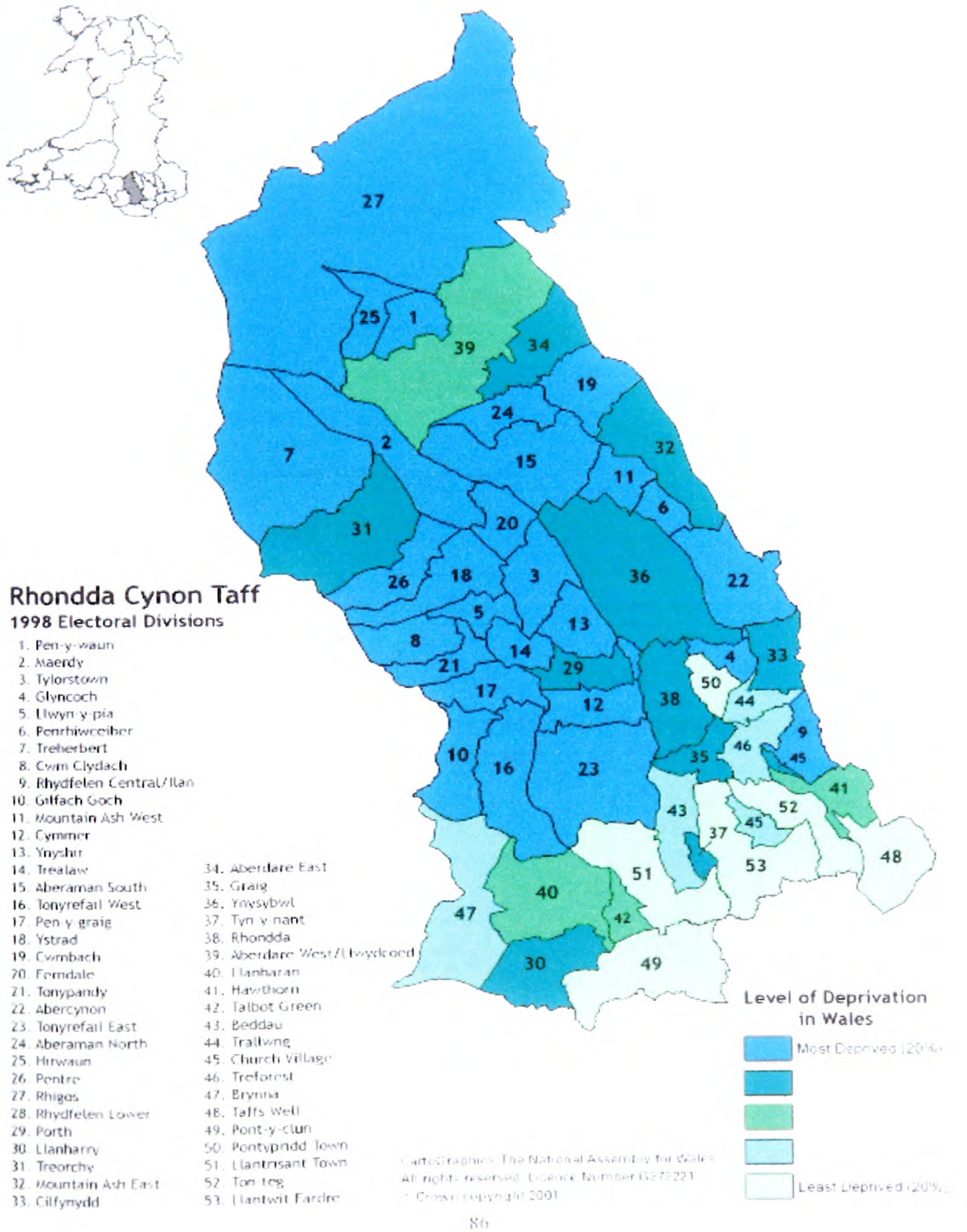
Appendices

Appendix A: Map of areas of relative deprivation in RCT



Source:

http://newydd.cymru.gov.uk/legacy_en/keypubstatisticsforwales/content/publication/social/2001/sb13-2001/rhondda-md2000.pdf

Appendix B: Quintiles of Deprivation

1 (Most deprived)	2	3	4	5 (Least deprived)
1. Pen-y-waun	13. Llwyn-y-pia	32. Llanharry	45. Taffs Well	48. Pontypridd Town
2. Rhydfelen Central/Ilan	14. Mountain Ash West	33. Porth	46. Brynna	49. Pont-y-clun
3. Glyncoch	15. Treforest	34. Mountain Ash East	47. Beddau	50. Llantrisant Town
4. Maerdy	16. Cwm Clydach	35. Rhigos		51. Ton-teg
5. Penrhiwceiber	17. Treaław	36. Tonypandy		52. Llantwit Fardre
6. Tylorstown	18. Ystrad	37. Aberdare West/Llwydcoed		
7. Aberaman South	19. Abercynon	38. Ynysybwl		
8. Gilfach Goch	20. Graig	39. Pentre		
9. Treherbert	21. Hirwaun	40. Rhondda		
10. Cymmer	22. Tyn-y-nant	41. Church Village		
11. Pen-y-graig	23. Cwmbach	42. Llanharan		
12. Ynyshir	24. Aberdare East	43. Talbot Green		
	25. Hawthorn	44. Trallwng		
	26. Ferndale			
	27. Aberaman North			
	28. Tonyrefail West			
	29. Treorchy			
	30. Tonyrefail East			
	31. Cilfynydd			

Source: Health information and analysis team, (2006). Deprivation and health for Rhondda Cynon Taff. National Public Health Service for Wales

Appendix C. Example of ASQ assessment.

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By Diane Bricker and Jane Squires
with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

48 Month • 4 Year Questionnaire

On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By Diane Bricker and Jane Squires
with assistance from Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly, and Jane Farrell

48 Month • 4 Year Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

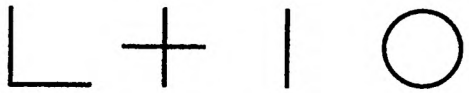
ASQ™

	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like, "Cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like, "Cow, dog, and elephant"?	❑	❑	❑	___
2. Does your child answer the following questions: "What do you do when you are hungry?" (Acceptable answers include: "Get food," "Eat," "Ask for something to eat," and "Have a snack.") Please write your child's response: _____ "What do you do when you are tired?" (Acceptable answers include: "Take a nap," "Rest," "Go to sleep," "Go to bed," "Lie down," and "Sit down.") Please write your child's response: _____ Mark "sometimes" if your child answers only one question.	❑	❑	❑	___
3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does he say something like, "It's round. I throw it. It's big"?	❑	❑	❑	___
4. Does your child use endings of words, such as "s," "ed," and "ing"? For example, does your child say things like, "I see two cats," "I am play*ing*," or "I kick*ed* the ball"?	❑	❑	❑	___
5. Without giving help by pointing or repeating, does your child follow three directions that are unrelated to one another? For example, you may ask your child to "Clap your hands, walk to the door, and sit down."	❑	❑	❑	___
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I *am* going to *the* park," or "*Is* there *a* toy to play with?" or "*Are* you coming, too?"	❑	❑	❑	___
		COMMUNICATION TOTAL		___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. Does your child catch a large ball with both hands? You should stand about 5 feet away and give your child two or three tries. 	❑	❑	❑	___
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	❑	❑	❑	___
3. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise her arm to shoulder height and throw the ball forward. (Dropping the ball, letting the ball go, or throwing the ball underhand should be scored as "not yet.") 	❑	❑	❑	___

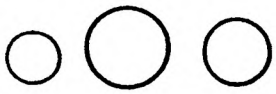
	YES	SOMETIMES	NOT YET	
GROSS MOTOR *(continued)*				
4. Does your child hop up and down on either the right or left foot at least one time without losing his balance or falling?	❑	❑	❑	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with her feet together?	❑	❑	❑	___
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing his balance and putting his foot down? You may give your child two or three tries before you mark the question. 	❑	❑	❑	___
		GROSS MOTOR TOTAL		___

FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child put together a six-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)	❑	❑	❑	___
2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? (Carefully watch your child's use of scissors for safety reasons.) 	❑	❑	❑	___
3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil or crayon, without tracing? Your child's drawings should look similar to the design of the shapes below, but they may be different in size.	❑	❑	❑	___



4. Does your child unbutton one or more buttons? Your child may use his own clothing or a doll's clothing.	❑	❑	❑	___
5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?	❑	❑	❑	___
6. Does your child color mostly within the lines in a coloring book? Your child should not go more than ¼ inch outside the lines on most of the picture.	❑	❑	❑	___
		FINE MOTOR TOTAL		___

	YES	SOMETIMES	NOT YET	
PROBLEM SOLVING *Be sure to try each activity with your child.*				
1. When you say, "Say five eight three," does your child repeat *just* these three numbers in the correct order? *Do not repeat these numbers.* If necessary, try another series of numbers and say, "Say six nine two." Your child must repeat just one series of three numbers to answer "yes" to this question.	❑	❑	❑	___
2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? Ask this question *without* providing help by pointing, gesturing, or looking at the smallest circle. 	❑	❑	❑	___
3. Without giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put a book "*under* the couch." Then ask her to put the ball "*between* the chairs" and the shoe "in the *middle* of the table."	❑	❑	❑	___
4. When shown an object and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? Answer "yes" only if your child answers the question correctly using five colors.	❑	❑	❑	___
5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother or sister, or an imaginary animal or figure.	❑	❑	❑	___
6. If you place five objects in front of your child, can he count them saying, "One, two, three, four, five," in order? Ask this question *without* providing help by pointing, gesturing, or naming.	❑	❑	❑	___
		PROBLEM SOLVING TOTAL		___
PERSONAL-SOCIAL *Be sure to try each activity with your child.*				
1. Does your child serve herself, taking food from one container to another using utensils? For example, can your child use a large spoon to scoop applesauce from a jar into a bowl?	❑	❑	❑	___
2. Does your child tell you at least four of the following: a. First name b. Age c. City she lives in d. Last name e. Boy or girl f. Telephone number Please circle the items your child knows.	❑	❑	❑	___
3. Does your child wash his hands and face using soap and dry off with a towel without help?	❑	❑	❑	___
4. Does your child tell you the names of two or more playmates, not including brothers and sisters? Ask this question without providing help by suggesting names of playmates or friends.	❑	❑	❑	___

	YES	SOMETIMES	NOT YET	
PERSONAL-SOCIAL *(continued)*				
5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all her teeth without help? You may still need to check and rebrush your child's teeth.	❑	❑	❑	___
6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)?	❑	❑	❑	___
			PERSONAL-SOCIAL TOTAL	___

OVERALL *Parents and providers may use the space below or the back of this sheet for additional comments.*

1. Do you think your child hears well? YES ❑ NO ❑
   If no, explain: _____
2. Do you think your child talks like other children her age? YES ❑ NO ❑
   If no, explain: _____
3. Can you understand most of what your child says? YES ❑ NO ❑
   If no, explain: _____
4. Do you think your child walks, runs, and climbs like other children his age? YES ❑ NO ❑
   If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES ❑ NO ❑
   If yes, explain: _____
6. Do you have any concerns about your child's vision? YES ❑ NO ❑
   If yes, explain: _____
7. Has your child had any medical problems in the last several months? YES ❑ NO ❑
   If yes, explain: _____
8. Does anything about your child worry you? YES ❑ NO ❑
   If yes, explain: _____

48 Month/4 Year ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

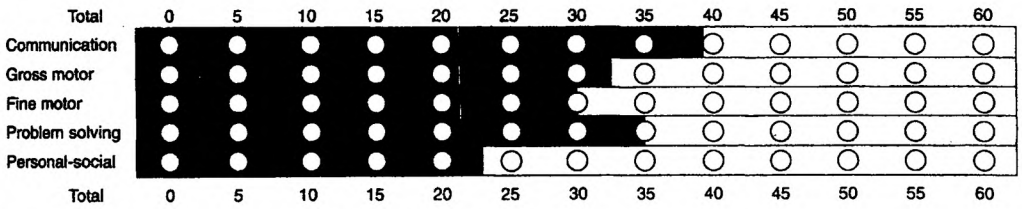
Today's date: _____ _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? Comments:	YES	NO	5. Family history of hearing impairment? Comments:	YES	NO
2. Talks like other children? Comments:	YES	NO	6. Vision concerns? Comments:	YES	NO
3. Understand child? Comments:	YES	NO	7. Recent medical problems? Comments:	YES	NO
4. Walks, runs, and climbs like others? Comments:	YES	NO	8. Other concerns? Comments:	YES	NO

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide.*
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ☐ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ■ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

48 months/4 years

	Score	Cutoff
Communication		39.1
Gross motor		32.9
Fine motor		30.0
Problem solving		35.0
Personal-social		23.4

	Communication	Gross motor	Fine motor	Problem solving	Personal-social
1	○○○	○○○	○○○	○○○	○○○
2	○○○	○○○	○○○	○○○	○○○
3	○○○	○○○	○○○	○○○	○○○
4	○○○	○○○	○○○	○○○	○○○
5	○○○	○○○	○○○	○○○	○○○
6	○○○	○○○	○○○	○○○	○○○
	Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____

Appendix D. Example of ASQ:SE assessment.

Ages & Stages Questionnaires: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim

24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE

Please read each question carefully and 1. Check the box ☐ that best describes your child's behavior *and* 2. Check the circle ○ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	☐z	☐v	☐x	○
2. Does your child seem too friendly with strangers?	☐x	☐v	☐z	○
3. Does your child laugh or smile when you play with her?	☐z	☐v	☐x	○
4. Is your child's body relaxed?	☐z	☐v	☐x	○
5. When you leave, does your child remain upset and cry for more than an hour? 	☐x	☐v	☐z	○
6. Does your child greet or say hello to familiar adults?	☐z	☐v	☐x	○
7. Does your child like to be hugged or cuddled?	☐z	☐v	☐x	○
8. When upset, can your child calm down within 15 minutes?	☐z	☐v	☐x	○
9. Does your child stiffen and arch his back when picked up?	☐x	☐v	☐z	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	☐z	☐v	☐x	○
11. Does your child cry, scream, or have tantrums for long periods of time?	☐x	☐v	☐z	○
12. Do you and your child enjoy mealtimes together?	☐z	☐v	☐x	○
13. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	☐x	☐v	☐z	○
14. Does your child sleep at least 10 hours in a 24-hour period?	☐z	☐v	☐x	○
15. When you point at something, does your child look in the direction you are pointing?	☐z	☐v	☐x	○
16. Does your child have trouble falling asleep at naptime or at night?	☐x	☐v	☐z	○
17. Does your child get constipated or have diarrhea?	☐x	☐v	☐z	○
18. Does your child follow simple directions? For example, does he sit down when asked?	☐z	☐v	☐x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?	❑z	❑v	❑x	○
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑z	❑v	❑x	○
21. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____. (You may write in something else.)	❑x	❑v	❑z	○
22. Does your child like to hear stories or sing songs? 	❑z	❑v	❑x	○
23. Does your child hurt himself on purpose?	❑x	❑v	❑z	○
24. Does your child like to be around other children? 	❑z	❑v	❑x	○
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑x	❑v	❑z	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	☐ x	☐ v	☐ z	○

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

28. Is there anything that worries you about your child? If so, please explain:

29. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ___

24 Month/2 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____

Person filling out the ASQ:SE: _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ:SE completion: _____

Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
	Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
24 months/2 years	50	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

Appendix E. Home assessment

RECORD FORM

Infant/Toddler HOME Record Form

Place a plus (+) or minus (-) in the box alongside each item if the behaviour is observed during the visit, or if the parent reports that the conditions or events are characteristic of the home environment. Enter the subtotals and the total on the **Summary Sheet** on page two.

I Responsivity

1 Parent permits child to engage in 'messy' play ☐
2 Parent spontaneously vocalises to child at least twice ☐
3 Parent responds verbally to child's vocalisations or verbalisations ☐
4 Parent tells child name of object or person during the visit ☐
5 Parent's speech is distinct, clear, and audible ☐
6 Parent initiates verbal interchanges with visitor ☐
7 Parent converses freely and easily ☐
8 Parent spontaneously praises child at least twice ☐
9 Parent's voice conveys positive feelings towards child ☐
10 Parent caresses or kisses child at least once ☐
11 Parent responds positively to praise of child offered by visitor ☐

II Acceptance

12 No more than 1 instance of physical punishment during past week ☐
13 Family has a pet ☐
14 Parent does not shout at child ☐
15 Parent does not express overt annoyance with or hostility to child ☐
16 Parent neither slaps nor spanks child during visit ☐
17 Parent does not scold or criticise child during visit ☐
18 Parent does not interfere with or restrict child more than 3 times during visit ☐
19 At least 10 books are present and visible ☐

III Organisation

20 Childcare, if used, is provided by 1 of 3 regular substitutes ☐
21 Child is taken to grocery store at least once a week ☐
22 Child gets out of home at least 4 times a week ☐
23 Child is taken regularly to doctor's office or clinic ☐
24 Child has a special place for toys and treasures ☐
25 Child's play environment is safe ☐

IV Learning materials

26 Muscle activity toys or equipment ☐
27 Push or pull toy ☐
28 Stroller or walker, kiddie car, scooter or tricycle ☐
29 Cuddly toys or role-playing toys ☐
30 Learning facilitators – mobile, table and chairs, high chair, play pen ☐
31 Simple eye–hand co-ordination toys ☐
32 Complex eye–hand co-ordination toys ☐
33 Toys for literature and music ☐
34 Parent provides toys for child to play with during visit ☐

V Involvement

35 Parent talks to child while doing household work ☐
36 Parent consciously encourages developmental advance ☐
37 Parent invests maturing toys with value through personal attention ☐
38 Parent structures child's play periods ☐
39 Parent provides toys that challenge child to develop new skills ☐
40 Parent keeps child in visual range, looks at often ☐

VI Variety

41 Father provides some care daily ☐
42 Parent reads stories to child at least 3 times weekly ☐
43 Child eats at least 1 meal per day with 'mother and father' ☐
44 Family visits relatives or receives visits once a month or so ☐
45 Child has 3 or more books of her/his own ☐

Totals	I	II	III	IV	V	VI	TOTAL

Appendix F. Risk factor questionnaire

The Impact of Rhondda Cynon Taff Sure Start on Children's development.

Child's name ... ...

Please be confident all this information will be considered as completely confidential, will be stored securely, and the identification sheet will be held separately from the questionnaire.

Baby/toddler : No. ☐ Date ☐ / /

Sure Start Service accessing.....

Pregnancy and birth information

Birthweight .....kg.s APGAR Score..... DoB..... Sex.....

How long was the pregnancy? ..... weeks

Any problems for you or the baby during the pregnancy: Yes/No. If yes can you tell us what?

.....

Any problems for you or the baby at the birth? Yes/No. If yes can you tell us what?

.....

Any problems in the Baby's health after birth and/or in first week of life, Yes/No.

If yes can you tell us what?.....

.....

How did you / do you feed the baby/child? Bottle , Breast , Used both

Does your child have special needs ? Yes/no/don't know If yes could you tell us what they are?.....

Child's health : Over the last 12 months would say your child's health has been:

Good Fairly good Not good

Mother's health : Over the last 12 months would say your own health has been:

Good Fairly good Not good

Would you say you have felt: Happy Quite happy Not at all happy

Do you think you have had/ are experiencing post natal depression?

Definitely, Not Sure, No

Do you feel you have received enough support since you had your child/children Yes, Not Sure, No

Did you smoke at all during the pregnancy? yes every day, yes some of the time, No not all

Did you drink at all during pregnancy? yes every day, yes some of the time, No not all

Did you use substances during pregnancy? yes every day, yes some of the time, No not all

The family:

Mums age ..... Dads age..... Are you: single married separated divorced

How many children to you have (please put in child's age)

1st child 2^{nd} child 3^{rd} child 4^{th} child 5^{th} child

Who lives with you and your child.....

If your child's other parent doesn't live with you, how often does he/she see your child?

Every day, every week, every couple of weeks, every month, less often, never

Education, training and employment

Mum left education at .....years old , highest qualification .....

Dad left education at ..... years old, highest qualification.....

Are you having any education or training at this time ? Mother : Yes/no

Father : Yes/no/don't know

Do you have a job at the moment ? Mother : Yes/no

Father : Yes/no

Does your child receive regular care from others? Yes/No

Who .....

How often.....Where.....

Which school will your child attend?..... When .....

Family income Under £5,000 ☐ £5,000 - £7,500 ☐ £7,500 - £10,000 ☐

£10,000- £12,500 ☐ 12,500 - £15,000 ☐ Over £15,000 ☐

Many thanks for your co-operation and time you have given to complete this questionnaire.

Appendix G. Study information sheet.

AN INVITATION

TO ALL PARENTS AND CHILDREN, LIVING IN RHONDDA CYNON TAFF, WHO ARE CONSIDERING USING RCT SURE START SERVICES FOR THE FIRST TIME.

You and your child are warmly invited to take part in a research study, being carried out by the University of Glamorgan.

Rhondda Cynon Taff

Rhondda Cynon Taf

Information Sheet:

A Study of the Health and Development of Children in the Rhondda Cynon Taff Sure Start Programme.

Invitation:

You are being invited to take part in a study. Before you decide whether to become included, it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If anything is not clear or if you would like to know more about the study, please ask. Take time to decide whether or not you would like to take part.

Thank you for reading this.

What is the purpose of the study?

Sure Start has been working in Rhondda Cynon Taff since 2000. One of the aims of the programme is to add to and improve support and services for children and families in the area, and as a result help the overall development of children. With the programme now established it is important to find out whether it is meeting this aim. The questions that the study is asking are

- Has the Sure Start Programme had an effect on the health or development of children who have used services or whose family has accessed services?
- Has Sure Start input helped the children's readiness for school?
- Are there needs of the children that have been unrecognised or have not been met?

To help us find this out, we will be asking parents or carers to let themselves and their children to become involved in the study.

Why have I been chosen?

We are inviting the parents or carers of all children aged up to 2 years old, who live in Rhondda Cynon Taff, and whose families are making contact with Sure Start Services to allow their family to be included in the study.

Do I have to take part?

It is entirely up to you to decide whether or not to participate and/or allow your child to take part. If you do decide to be part of the study you will be given this information sheet to keep and will be asked to sign a consent form giving permission for your child to take part, and a separate one for yourself if you would like to be involved. You are free to withdraw this permission at any time and do not have to explain why you wish to withdraw. Any decision about taking part in the study will not affect the standard or type of care you receive.

What will happen to me if I take part?

The study will take approximately 2 hours, in total, of your time, spread out over 2 years. Before using programme services a university researcher would like to visit you and your child. During the visit we would like to find out:

- a little about you and your child,
- what you feel it is like being a parent,
- your concerns for your child,
- how you feel your child is progressing,
- your views on your community,
- what you think would help you in your role as a parent,
- what you hope your family may gain from the Sure Start service(s) you or your child are about to use.

We would like to contact you a couple of times more during the study, by telephone if this is possible , to see how things are going.

At the end of the study we would like to visit you again, to chat about your experiences over the time of the study.
If your child has begun school by this time, their teacher will have carried out a routine assessment, one they perform for all new pupils. This is to help teachers discover where each child is, in relation to skills that will be further developed at school. We would really like to have your permission to allow the teachers to share the results of the assessment for your child with the researcher.

What do I have to do?

If you decide to help us in this research, give your contact details to the Staff member who gave you this invitation. We will then contact you to arrange the first visit, this would be best carried out at your home, and will take about 60 minutes.

What are the possible benefits of taking part?

We want to find out whether or not the Sure Start programme, as currently provided, is helping children develop. If we find it has been beneficial, it will enable the services to continue and also guide improvements. If no positive effect is found, we can use the information you give us to shape Sure Start services in a way that would better meet the concerns and needs of your families and children .

What happens when the study stops:

The study is independent of the working of the Sure Start programme. Sure Start services will continue, using the findings of the study to help plan future work.

What if some thing goes wrong?

If you feel that something has gone wrong, you are encouraged to contact the researcher or Sure Start Staff, and every effort will be made to rectify matters.

What happens to the results of the research study?

The results will be used by the Sure Start Programme to inform them about the effectiveness of their work in Rhondda Cynon Taff. We will hold meetings throughout RCT to tell interested parents about our findings.

Who is organising and funding the Research?

The Rhondda Cynon Taff Local Authority is funding the study. The University of Glamorgan is organising and conducting the Study.

Contacts: Annie Williams 01443 483085
07746 760511

Appendix H. Consent form.

Rhondda Cynon Taff

Sure Start

Rhondda Cynon Taf

CONSENT FORM

Name of researcher : Anne Williams

Please Initial Box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions ☐

2. I understand that my participation is voluntary, and that I am free to withdraw at any time, without giving any reason. ☐

3. I .....agree to take part in the above study. ☐

....

Date Signature

Witness Signature .....

Appendix I

Interview schedule Phase 1

1. Collect background data.
2. ASQ & ASQ:SE if not completed prior to visit.
3. Ask for description of typical day in the life of child from the moment he/she wakes up until they go to bed.
4. How did family come in contact with services?

   Supplemental questions if needed:

   Was it easy to decide to use services?

   What are you hoping the services can do for you and your family

   Do you think some people would be reluctant to use services?

   Can you think why ?

5. Have you ever been asked what your needs are for your child, for you as an individual, a parent or as part of the community?

   If you have

   Do you feel your needs have been taken into account or met?

6. What would help, what are your needs?
7. What do you hope for your children in the future?
8. What are your hope/plans for yourself?

Appendix J.

Interview schedule phase 2.

Questions after first service use

1. Looking back who sorted out the SS activity use?

2. How did you start use? How did you get there (if outside house)
   What did you expect? Who arranged time?

3. Can you describe the experience, a session with/of .....(what ever service was)

   Supplementary questions if not offered in description:

   What do you think of it?

   How long did you go?

   Did it have any effect on X?

   Has it changed any thing? For child? For you?

4. Have you heard about the service any other way?

5. Are you using other additional activities/services?

6. So looking back to summarise, what would you say about services and what has it done for you?'

7. Has anything else in the family, or the things you do together changed since last we met?

8. If it has, how did this happen?

9. Does he/she like it?

10. Anything else you would like to say?

11. Have you any current concerns for X?

Appendix K

Interview schedule phase 3.

Visit after interval since initial service use

1. Since our last visit has anything changed for the family?
2. For .....(child)
3. Do you have any concerns for.....?
4. After you finished the Sure Start Service you felt that.....:
    a. If change were perceived: Do you think that has continued?
    b. Looking back do you think now that the service had any effect? (on child, on what you do with him/her, anything else)
    c. Do you have any concerns about ..... (child's name)

5. Have you heard of any other activities or services since our last meeting? If yes: how did you hear?
6. Overall, looking back what do you think of the service you used?
7. If used more than one, of Sure Start services generally?
8. Do you feel Sure start has had a lasting effect on ..... (child name)?
   on you or the family?

Appendix L: Correlation of qualitative assessments and HOME scores

		HOME total score	Qualitative developmental environment
HOME total score	Pearson Correlation	1	.865(**)
	Sig. (2-tailed)		.000
	N	29	29
qualitative developmental environment	Pearson Correlation	.865(**)	1
	Sig. (2-tailed)	.000	
	N	29	32

** Correlation is significant at the 0.01 level (2-tailed).

		Qualitative development al environment
qualitative developmental environment	Pearson Correlation	1
	Sig. (2-tailed)	
	N	29
acceptance	Pearson Correlation	.381(*)
	Sig. (2-tailed)	.032
	N	29
Responsitivity	Pearson Correlation	.805(**)
	Sig. (2-tailed)	.000
	N	29
organisation	Pearson Correlation	.468(**)
	Sig. (2-tailed)	.007
	N	29
Learning organisation	Pearson Correlation	.693(**)
	Sig. (2-tailed)	.000
	N	29
Involvement	Pearson Correlation	.764(**)
	Sig. (2-tailed)	.000
	N	29
Variety	Pearson Correlation	.724(**)
	Sig. (2-tailed)	.000
	N	29

* Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Appendix M: Pre-service use differences in HOME subscores for multi and lower risk families.

Group Statistics

	No. risk factors	N	Mean	Std. Deviation	Std. Error Mean
Acceptance	four or more	7	5.50	1.604	.567
	up to three	22	6.46	.833	.170
Responsitivity	four or more	7	4.63	1.506	.532
	up to three	22	8.46	2.064	.421
Organisation	four or more	7	3.75	1.035	.366
	up to three	22	5.13	1.076	.220
Learning organisation	four or more	7	5.00	1.414	.500
	up to three	22	7.33	1.404	.287
Involvement	four or more	7	1.50	1.414	.500
	up to three	22	4.42	1.792	.366
Variety	four or more	7	1.88	.835	.295
	up to three	22	4.00	.933	.190

Appendix M (continued) Independent Samples Test: Pre-service use differences in HOME subscores beween multi and lower risk families.

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
acceptance	Equal variances assumed	5.60	.03	-2.21	30	.035	-.96	.43	-1.84	-.07
	Equal variances not assumed			-1.62	8.29	.143	-.96	.59	-2.31	.39
Responsi tivity	Equal variances assumed	5.23	.03	-4.82	30	.000	-3.83	.79	-5.45	-2.20
	Equal variances not assumed			-5.65	16.53	.000	-3.83	.67	-5.26	-2.39
organisation	Equal variances assumed	.00	.97	-3.16	30	.004	-1.37	.43	-2.26	-.48
	Equal variances not assumed			-3.23	12.45	.007	-1.37	.42	-2.30	-.44
Learning organisation	Equal variances assumed	.14	.71	-4.06	30	.000	-2.33	.57	-3.50	-1.16
	Equal variances not assumed			-4.05	11.96	.002	-2.33	.57	-3.58	-1.07
Involvement	Equal variances assumed	.90	.35	-4.18	30	.000	-2.91	.69	-4.34	-1.49
	Equal variances not assumed			-4.71	15.17	.000	-2.91	.61	-4.23	-1.59
Variety	Equal variances assumed	.00	.97	-5.77	30	.000	-2.12	.37	-2.88	-1.36
	Equal variances not assumed			-6.05	13.33	.000	-2.12	.35	-2.88	-1.36

Appendix N: ASQ & ASQ:SE scores for participant focus children.

Participant 1 Attrition: No service use.

Age 11 weeks Reason for referral: young isolated mum
Service: CCW stimulation

ASQ:SE Total score = 20
Cut off scores = 45 Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	33.3	No	16.7
Gross Motor	30	40.1	Yes	-10
Fine Motor	35	27.5	No	7.5
Problem solving	20	35.0	Yes	-15
Personal, social	40	33.0	No	

Phase 2 scores. 6 months after no take up of offered service at all.

Age 10 months
ASQ:SE Total score = 35
Cut off scores = 48 Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	25.0	No	30
Gross Motor	30	17.5	No	12.5
Fine Motor	40	39.0	No	1
Problem solving	40	30.5	No	10
Personal, social	40	30.0	No	

Phase 3
Age 2 years

ASQ:SE Total score = 60
Cut off scores = 50 Status: ASQ :SE = At risk

Skill	Score	Cut off	Risk	Sc – cut off
Communication	20	36.5	yes	- 16.5
Gross Motor	35	36.0	yes	-1.00
Fine Motor	50	36.4	no	13.5
Problem solving	40	32.9	no	17.1

HOME Scores Pt. 1

Subscale	Score Ph1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	5	6	4	0-6	7-9	10-11	L	L
Acceptance	6	6	6	0-4	5-6	7-8	M	M
Organisation	5	3	3	0-3	4-5	6	M	L
Learning Materials	4	7	4	0-4	5-7	8-9	L	M
Involvement	3	3	0	0-2	3-4	5-6	M	M
Variety	3	2	2	0-1	2-3	4-5	M	M
Total score	26							

Participant 2

Age 13 weeks
Service: CCW

Reason for referral: Young, isolated mum stimulation

ASQ:SE Total score = 5
Cut off scores = 45

Status: OK

ASQ

Skill	Score	Cut off	Risk
Communication	50	33.3	No
Gross Motor	40	40.1	?
Fine Motor	30	27.5	No
Problem solving	25	35	Yes
Personal, social	40	33	No

HOME Score

Subscale	Score Ph 1	Lowest fourth	Middle half	Upper fourth	Position
Responsivity	7	0-6	7-9	10-11	M
Acceptance	7	0-4	5-6	7-8	U
Organisation	4	0-3	4-5	6	M
Learning Materials	4	0-4	5-7	8-9	L
Involvement	1	0-2	3-4	5-6	L
Variety	3	0-1	2-3	4-5	M
Total score					

Participant 3

Age 12 months

Reason for referral: Depressed Mum
Service: Counsellor

ASQ:SE Total score = 30
Cut off scores = 48

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	45	15.8	No	29.2
Gross Motor	60	18.0	No	42
Fine Motor	40	28.4	No	11.6
Problem solving	25	25.2	Yes	-0.5
Personal, social	45	20.1	No	

Phase 2

Age 20 months

Reason for referral: PND
Service: Counsellor

ASQ:SE Total score = 35
(18 mths) Cut off scores = 50

Status: OK

ASQ (20 months)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	36.5	No	13.5
Gross Motor	55	36.2	No	18.8
Fine Motor	30	39.8	Yes	-10
Problem solving	20	29.9	Yes	-10

Phase 3

34 months

ASQ:SE Total score = 35
Cut off scores = 59

Status: ok

ASQ

Skill	Score	Cut off	Risk
Communication	60	35.0	No
Gross Motor	45	41.5	No
Fine Motor	60	29.5	No
Problem solving	45	36.5	No

HOME Scores Pt.3

Subscale	Score Ph1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position 1	Ph 2	Ph 3
Responsivity	6	6	7	0-6	7-9	10-11	L	L	M
Acceptance	6	6	7	0-4	5-6	7-8	M	M	U
Organisation	6	5	4	0-3	4-5	6	U	M	M
Learning Materials	7	7	8	0-4	5-7	8-9	M	M	U
Involvement	0	2	4	0-2	3-4	5-6	L	L	M
Variety	4	4	4	0-1	2-3	4-5	U	U	U
Total score									

Participant 4

Age 24 months

Reason for referral: Communication
Service: CCW

ASQ:SE Total score = 25
Cut off scores = 50 Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	25	36.5	Yes	-11.5
Gross Motor	60	36.0	No	24
Fine Motor	50	36.4	No	13.6
Problem solving	55	32.9	No	22

Phase 2
Age 33 months
ASQ:SE Total score = 45
Cut off scores = 59 Status: OK

ASQ (33 months)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	35	No	+15
Gross Motor	60	41.5	No	14
Fine Motor	50	29.5	No	19
Problem solving	55	36	No	16

Phase 3
Age 39 months
ASQ:SE Total score = 30
Cut off scores = 59 Status: OK

ASQ (36 months)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	38.7	No	21.3
Gross Motor	60	35.7	No	24.3
Fine Motor	60	30.7	No	29.3
Problem solving	60	38.6	No	21.4

HOME Score

Subscale	Score Ph1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	11	11	10	0-6	7-9	10-11	U	U	U
Acceptance	7	7	7	0-4	5-6	7-8	U	U	U
Organisation	6	6	6	0-3	4-5	6	U	U	U
Learning Materials	9	9	9	0-4	5-7	8-9	U	U	U
Involvement	6	6	6	0-2	3-4	5-6	U	U	U
Variety	4	5	5	0-1	2-3	4-5	U	U	U
Total score	43	44	43						

Participant 5 Phase 1

Age 33 months Reason for referral: self
Service: next steps

ASQ:SE Total score = 50
Cut off scores = 59 Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	35.0	No	25
Gross Motor	60	41.5	No	18.5
Fine Motor	55	29.5	No	25.5
Problem solving	50	36.5	No	13.5

Phase 2

Age 40 months Reason for referral: self
Service: Next Steps still using

ASQ:SE Total score = 35
Cut off scores = 59 Status: OK

ASQ (42 mnth)

Communication	50	38	No	12
Gross Motor	55	45	No	10
Fine Motor	60	40	No	20
Problem solving	60	49	No	check

Phase 3

Age 53 months Reason for referral: self
Service: Next Steps still using

ASQ:SE Total score = 30
Cut off scores = 70 Status: OK

ASQ (54 mnth)

Communication	55	50.0	No	5
Gross Motor	60	42.5	No	17.5
Fine Motor	55	26.5	No	28.5
Problem solving	60	33.0	No	27.0

HOME Scores Pt.5

Subscale	Score Ph 1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	10	11	11	0-6	7-9	10-11	U	U	U
Acceptance	7	8	9	0-4	5-6	7-8	U	U	U
Organisation	6	5	5	0-3	4-5	6	U	U	U
Learning Materials	9	9	9	0-4	5-7	8-9	U	U	U
Involvement	6	6	6	0-2	3-4	5-6	U	U	U
Variety	5	5	5	0-1	2-3	4-5	U	U	U
Total score									

Participant 6 Phase 1

Age 33 months Reason for referral: Self
Service:

ASQ:SE Total score = 40
Cut off scores = 59 Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	35.0	No	25
Gross Motor	60	41.5	No	18.5
Fine Motor	50	29.5	No	20.5
Problem solving	60	36.5	No	23.5
Personal, social				

Phase 2
Age 40 months Reason for referral: self
Service: Next Steps

ASQ:SE Total score = 35
Cut off scores = 59 Status: OK

ASQ (42 month)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	38	No	12
Gross Motor	55	45	No	10
Fine Motor	60	40	No	20
Problem solving	45	49	check	check

Phase 3
Age 40 months Reason for referral: self
Service: Next Steps

ASQ:SE Total score =
Cut off scores = Status: OK

ASQ (54 mnth)

Communication	60	50.0	No	5
Gross Motor	55	42.5	No	17.5
Fine Motor	60	26.5	No	28.5
Problem solving	60	33.0	No	27.0

HOME Scores Pt.6

Subscale	Score Ph 1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	10	11	11	0-6	7-9	10-11	U	U	U
Acceptance	7	8	9	0-4	5-6	7-8	U	U	U
Organisation	6	5	5	0-3	4-5	6	U	U	U
Learning Materials	9	9	9	0-4	5-7	8-9	U	U	U
Involvement	6	6	6	0-2	3-4	5-6	U	U	U
Variety	5	5	5	0-1	2-3	4-5	U	U	U
Total score									

Participant 7

Phase 1
Age 24 months

Reason for referral: Speech
Service: CCW

ASQ:SE Total score = 30
Cut off scores = 50

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc –cut off
Communication	15	36.5	Yes	-21.5
Gross Motor	55	36	No	19
Fine Motor	40	36.5	No	13.5
Problem solving	20	33.3	Yes	-13.3

Phase 2
Age 28 months

ASQ:SE Total score = 40
Cut off scores = 57

Status: OK

ASQ (27 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	30	33.5	Yes	-3.5
Gross Motor	45	35.0	No	10
Fine Motor	30	26	No	4
Problem solving	30	37	Yes	-7

HOME Score

Subscale	Score Ph1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	8	7	0-6	7-9	10-11	M	M
Acceptance	5	5	0-4	5-6	7-8	M	M
Organisation	6	6	0-3	4-5	6	U	U
Learning Materials	9	9	0-4	5-7	8-9	U	U
Involvement	4	6	0-2	3-4	5-6	M	U
Variety	5	5	0-1	2-3	4-5	U	U
Total score							

Participant 8

Phase 1
Age 28 months

Reason for referral: Behaviour
Service:

ASQ:SE Total score = 115
Cut off scores = 57

Status: ASE:SE: at risk

ASQ (27 month)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	45	33.5	No	11.5
Gross Motor	60	35	No	25
Fine Motor	35	26	No	9
Problem solving	20	37	Yes	-17

Phase 2
Age 34 months

Reason for referral: Behaviour
Service:

ASQ:SE Total score = 90
Cut off scores = 59

Status: still at risk

ASQ (36 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	35	35.0	On line	0
Gross Motor	45	41.5	No	3.5
Fine Motor	15	29.5	Yes	-14.5
Problem solving	45	36.5	No	8.5

Phase 3
Age 41 months

ASQ:SE Total score = 85
Cut off scores = 59

Status: still at risk

ASQ (42 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	40	38.0	No	2
Gross Motor	40	45.0	yes	-1.5
Fine Motor	30	40.0	yes	-10
Problem solving	40	39.0	No	1.0

HOME Scores Pt 8

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	5	3	0-6	7-9	10-11	L	L
Acceptance	6	5	0-4	5-6	7-8	M	M
Organisation	4	3	0-3	4-5	6	M	M
Learning Materials	6	3	0-4	5-7	8-9	M	M
Involvement	0	1	0-2	3-4	5-6	L	L
Variety	1	1	0-1	2-3	4-5	L	L
Total score							

Participant 9

Age 26 months

Reason for referral: Speech
Service: CCW

ASQ:SE Total score = 30
Cut off scores = 50 Status: OK

ASQ

Skill	Score	Cut off	Risk
Communication	30	36.5	Yes
Gross Motor	35	36	yes
Fine Motor	40	36.4	No
Problem solving	40	32.9	No

Age 28 months

ASQ:SE Total score = 25
Cut off scores = 50 Status: OK

ASQ

Skill	Score	Cut off	Risk
Communication	35	36.5	Yes
Gross Motor	35	36	Yes
Fine Motor	40	36.4	No
Problem solving	45	32.9	No

HOME Score

Subscale	Score Ph1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	7	7	0-6	7-9	10-11	M	M
Acceptance	7	7	0-4	5-6	7-8	U	U
Organisation	6	6	0-3	4-5	6	U	U
Learning Materials	8	8	0-4	5-7	8-9	U	U
Involvement	5	5	0-2	3-4	5-6	U	U
Variety	3	4	0-1	2-3	4-5	M	M
Total score							

Participant 10

Phase 1

Age 28 months

Reason for referral: behaviour and concentration
Service: CCW

ASQ:SE Total score = 95
Cut off scores = 57

Status: At risk

ASQ (27 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	33.5	No	21.5
Gross Motor	60	35	No	25
Fine Motor	30	26	No	4
Problem solving	40	37	No	3

Phase 2 scores
Age 35 months

ASQ:SE Total score = 55
Cut off scores = 59

Status: OK

ASQ (36 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	38.7	No	16
Gross Motor	50	35.7	No	14
Fine Motor	60	30.7	No	29
Problem solving	50	38.6	No	11

Phase 3
Age 41 months
ASQ:SE Total score = 55
Cut off scores = 59

Status: OK

ASQ (36 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	38.0	No	17.0
Gross Motor	60	45.0	No	15.0
Fine Motor	60	40.0	No	20.0
Problem solving	60	42.5	No	17.5

HOME Scores Pt 10

Subscale	Score Ph 1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	6	9	10	0-6	7-9	10-11	L	M	U
Acceptance	6	7	6	0-4	5-6	7-8	M	U	M
Organisation	5	6	5	0-3	4-5	6	M	U	M
Learning Materials	6	9	7	0-4	5-7	8-9	M	U	M
Involvement	1	5	5	0-2	3-4	5-6	L	U	U
Variety	3	4	4	0-1	2-3	4-5	M	U	U
Total score									

Participant 11

Still attending group, but no response to study.

Age 13 months

Reason for referral: self
Service: Mother and toddler

ASQ:SE Total score = 40
Cut off scores = 48

Status: OK

ASQ

Skill	Score	Cut off	Risk
Communication	40	31	No
Gross Motor	45	24	No
Fine Motor	60	25	No
Problem solving	55	28.5	No

HOME Score

Subscale	Score Ph 1	Lowest fourth	Middle half	Upper fourth	Position
Responsivity	5	0-6	7-9	10-11	L
Acceptance	5	0-4	5-6	7-8	M
Organisation	5	0-3	4-5	6	M
Learning Materials	8	0-4	5-7	8-9	U
Involvement	3	0-2	3-4	5-6	M
Variety	5	0-1	2-3	4-5	U
Total score					

Participant 12

Age 15 months

Reason for referral: self
Service: Mother and toddler

ASQ:SE Total score = 25
Cut off scores = 50

Status: ok

ASQ (14 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	31	No	29
Gross Motor	55	24	No	31
Fine Motor	40	25	No	15
Problem solving	40	28.5	No	12.5

Phase 2
Age 21 months

Service: Mother and toddler
Still being used

ASQ:SE Total score = 25
Cut off scores = 50

Status: ok

ASQ (20 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	36.3	No	23.7.2
Gross Motor	55	36.2	No	18.8
Fine Motor	50	39.8	No	10.2
Problem solving	50	29.9	No	21.1

Phase 3
Age 34 months

ASQ:SE Total score = 30
Cut off scores = 59

Status: OK

ASQ (36 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	39	No	11
Gross Motor	50	36	No	14
Fine Motor	60	31	No	29
Problem solving	50	39	No	11

HOME Scores Pt 12

Subscale	Score Ph 1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	6	9	9	0-6	7-9	10-11	L	M	M
Acceptance	7	7	8	0-4	5-6	7-8	U	U	U
Organisation	6	6	6	0-3	4-5	6	U	U	U
Learning Materials	7	7	7	0-4	5-7	8-9	M	M	M
Involvement	3	6	6	0-2	3-4	5-6	M	U	U
Variety	5	4	4	0-1	2-3	4-5	U	U	U
Total score									

Participant 13

Age 20 months

Reason for referral: self
Service: Mother and Toddler

ASQ:SE Total score = 35
Cut off scores = 50

Status: OK

ASQ (20 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	36.5	No	23.5
Gross Motor	60	36.2	No	23.8
Fine Motor	60	39.8	No	20
Problem solving	55	29.9	No	20

Phase 2
Age 27 months

Reason for referral: Self
Service: Mother and Toddler

ASQ:SE Total score = 5
Cut off scores = 50

Status: OK

ASQ (27 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	33.5	No	21.5
Gross Motor	60	35	No	25
Fine Motor	35	26	No	9
Problem solving	60	37	No	23

Phase 3
Age 36 months

ASQ:SE Total score = 50
Cut off scores = 59

Status: OK

ASQ (36 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	38.7	No	21.3
Gross Motor	55	35.7	No	19.3
Fine Motor	55	30.7	No	24.3
Problem solving	50	38.6	No	11.4

HOME Scores Pt 13

Subscale	Score Ph1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	11	11	11	0-6	7-9	10-11	U	U
Acceptance	7	8	8	0-4	5-6	7-8	U	U
Organisation	6	6	6	0-3	4-5	6	U	U
Learning Materials	9	8	9	0-4	5-7	8-9	U	U
Involvement	4	6	6	0-2	3-4	5-6	M	U
Variety	4	5	5	0-1	2-3	4-5	U	U
Total score								

Participant 14

Age 22 weeks

Reason for referral: self
Service: baby massage

ASQ:SE Total score = 5
Cut off scores = 45

Status: ok

ASQ (6 mnth)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	29	No	31
Gross Motor	40	19.5	No	20.5
Fine Motor	40	27.5	No	12.5
Problem solving	60	37.5	No	22.5

HOME Score

Subscale	Score	Lowest fourth	Middle half	Upper fourth	Position
Responsivity	10	0-6	7-9	10-11	U
Acceptance	6	0-4	5-6	7-8	M
Organisation	5	0-3	4-5	6	M
Learning Materials	6	0-4	5-7	8-9	M
Involvement	4	0-2	3-4	5-6	M
Variety	4	0-1	2-3	4-5	U
Total score					

Participant 15

Age 11 weeks

Reason for referral: Self
Service: baby gym

ASQ:SE Total score = 0
(6 mnths) Cut off scores = 45

Status: OK

ASQ (4 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	33.3	No	16.7
Gross Motor	20	40.1	Yes	-20.1
Fine Motor	25	27.5	Yes	-2
Problem solving	30	35.0	Yes	-5

Phase 2
(12 months)
ASQ:SE Total score = 20
Cut off scores = 48

Status: OK

ASQ (10 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	40	25.0	No	15
Gross Motor	60	17.5	No	42.5
Fine Motor	60	39.0	No	21
Problem solving	60	30.5	No	29.5

Phase 3
Age 20 months
ASQ:SE Total score = 10
Cut off scores = 50

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc –cut off
Communication	20	36.3	yes	-16.3
Gross Motor	60	36.2	No	23.8
Fine Motor	40	39.8	No	0.2
Problem solving	50	29.9	No	20.1

HOME Scores Pt 15

Subscale	Score Ph 1	Phase 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 3
Responsivity	10	8	0-6	7-9	10-11	U	M
Acceptance	7	7	0-4	5-6	7-8	U	U
Organisation	2	3	0-3	4-5	6	L	L
Learning Materials	4	4	0-4	5-7	8-9	L	L
Involvement	5	3	0-2	3-4	5-6	U	M
Variety	2	3	0-1	2-3	4-5	M	M
Total score							

Participant 16

Age 12 months

Reason for referral: self
Service: Mother and toddler

ASQ:SE Total score = 55
Cut off scores = 48

Status: At risk

ASQ (12 mnths)

Skill	Score	Cut off	Risk	
Communication	50	15.8	No	34.2
Gross Motor	55	18	No	37
Fine Motor	45	28.4	No	16.6
Problem solving	45	25.2	No	19.8

Phase 2
Age 20 months

ASQ:SE Total score = 70
Cut off scores = 50

Status: At risk

ASQ (20 mnths)

Skill	Score	Cut off	Risk	SC-cut off
Communication	35	36.3	Yes	-1.3
Gross Motor	55	36.2	No	18.8
Fine Motor	40	39.8	No	1.2
Problem solving	45	29.9	No	15.1

Phase 3
Age 30 months
ASQ:SE Total score = 35
Cut off scores = 57

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc- cut off
Communication	40	38.8	No	1.2
Gross Motor	50	30.6	No	19.4
Fine Motor	30	25.2	No	4.8
Problem solving	30	28.9	No	1.1

HOME Scores Pt 16

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	7	5	0-6	7-9	10-11	M	M
Acceptance	6	6	0-4	5-6	7-8	M	M
Organisation	5	5	0-3	4-5	6	M	M
Learning Materials	6	7	0-4	5-7	8-9	M	M
Involvement	2	3	0-2	3-4	5-6	L	M
Variety	3	3	0-1	2-3	4-5	M	M
Total score							

Participant 17

Age 10 months (age adjusted - premature.) Reason for referral: birth trauma
Service: Counsellor

ASQ:SE Total score = 45
Cut off scores = 48 Status: OK (marginal)

ASQ (10 months)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	35	25.0	No	10
Gross Motor	25	17.5	No	7.5
Fine Motor	40	39.0	No	1
Problem solving	50	30.5	No	19.5

Phase 2
Age 17 months (age adjusted)

ASQ:SE Total score = 40
(18 months) Cut off scores = 50 Status: OK

ASQ (16 months)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	30	34.5	Yes	-4.5
Gross Motor	35	32.3	No	2.7
Fine Motor	40	30.6	No	9.6
Problem solving	25	26.9	Yes	-1.9

HOME Score

Subscale	Score Ph 1	Ph.2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	4	7	0-6	7-9	10-11	L	M
Acceptance	7	7	0-4	5-6	7-8	U	U
Organisation	5	5	0-3	4-5	6	M	M
Learning Materials	7	7	0-4	5-7	8-9	M	M
Involvement	2	4	0-2	3-4	5-6	L	M
Variety	2	2	0-1	2-3	4-5	M	M
Total score							

Participant 18

Phase 1
Age 27 months

Reason for referral: Financial help
Service: Assisted places

ASQ:SE Total score = 15
Cut off scores = 57

Status: OK

ASQ (27mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	33.5	No	26.5
Gross Motor	60	35.0	No	25
Fine Motor	60	26.0	No	24
Problem solving	60	37.0	No	23

Phase 2
Age 35 months

still using assisted places funding

ASQ:SE Total score = 20
Cut off scores = 59

Status: OK

ASQ (36 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	38.7	No	21.3
Gross Motor	55	35.7	No	19.3
Fine Motor	50	30.7	No	19.3
Problem solving	60	38.6	No	21.4

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	10	10	0-6	7-9	10-11	U	U
Acceptance	7	7	0-4	5-6	7-8	U	U
Organisation	4	5	0-3	4-5	6	M	M
Learning Materials	7	8	0-4	5-7	8-9	M	U
Involvement	5	5	0-2	3-4	5-6	U	U
Variety	4	4	0-1	2-3	4-5	U	U
Total score	37						

Participant 19

Phase 1
Age 35 months

Reason for referral: CCW
Service: Communication

ASQ:SE Total score = 30
Cut off scores = 59

Status: OK

ASQ (36 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	38.7	No	21
Gross Motor	40	35.7	No	4
Fine Motor	50	30.7	No	19
Problem solving	40	38.7	No	1

Age 36 months

Finished input from SSCCW

Phase 2
ASQ:SE Total score = 35
Cut off scores = 59

Status: OK

ASQ (36 mnths)

Skill	Phase2/3	Cut off	Risk	Sc – cut off
Communication	50	38.7	No	11
Gross Motor	40	35.7	No	4
Fine Motor	35	30.7	No	4
Problem solving	30	38.7	yes	-9

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	11	11	0-6	7-9	10-11	U	U
Acceptance	7	7	0-4	5-6	7-8	U	U
Organisation	6	6	0-3	4-5	6	U	U
Learning Materials	9	9	0-4	5-7	8-9	U	U
Involvement	6	6	0-2	3-4	5-6	U	U
Variety	5	5	0-1	2-3	4-5	U	U
Total score	44						

Participant 20

Phase 1
Age 47 months

Reason for referral: Diet
Service: SS Health Visitor

ASQ:SE Total score = 65
Cut off scores = 70

Status: OK

ASQ (48 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	35	39.1	Yes	-4
Gross Motor	50	32.9	No	17
Fine Motor	45	30	No	15
Problem solving	50	35	No	15

Phase 2

Age 49 months
ASQ:SE Total score = 45
Cut off scores = 70

Status: OK

ASQ (49 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	39.1	No	5
Gross Motor	50	32.9	No	7.5
Fine Motor	30	30	No	4.5
Problem solving	60	35	No	27

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	ph 2
Responsivity	11	9	0-6	7-9	10-11	U	M
Acceptance	8	7	0-4	5-6	7-8	U	M
Organisation	5	5	0-3	4-5	6	M	M
Learning Materials	7	7	0-4	5-7	8-9	M	M
Involvement	5	5	0-2	3-4	5-6	U	U
Variety	3	3	0-1	2-3	4-5	M	M
Total score	39						

Participant 21
Age 11 months

Reason for referral: Developmental delay
Service: CCW

ASQ:SE Total score = 25
Cut off scores = 48

Status: OK

ASQ (12 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	20	15.8	No	4.2
Gross Motor	5	18.0	Yes	-13
Fine Motor	45	28.4	No	16.6
Problem solving	20	25.2	Yes	-5.2

Phase 2
Age 16 mnths

ASQ:SE Total score = 35
Cut off scores = 50

Status: OK

ASQ (16 mnths)

Skill	Score	Cut off	Risk	Sc –cut
Communication	35	34.5	No	0.5
Gross Motor	10	32.3	Yes	-22.3
Fine Motor	40	30.6	No	9.4
Problem solving	40	26.9	No	13.1

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	6	2	0-6	7-9	10-11	L	L
Acceptance	6	6	0-4	5-6	7-8	M	M
Organisation	2	4	0-3	4-5	6	L	M
Learning Materials	4	4	0-4	5-7	8-9	L	L
Involvement	4	1	0-2	3-4	5-6	M	L
Variety	1	1	0-1	2-3	4-5	L	L
Total score	23						

Participant 22

Phase 1
Age 10 months

Reason for referral: Sleep Problems
Service: SS HV

ASQ:SE Total score = 60
Cut off scores = 48

Status: at risk

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	45	25.0	No	20
Gross Motor	60	17.5	No	42.5
Fine Motor	60	39.0	No	21
Problem solving	45	30.5	No	14.5

Phase 2
Finished SSHV input
Age 12 months:

ASQ:SE Total score = 35
Cut off scores = 48

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	15.8	No	44.2
Gross Motor	60	18.0	No	42
Fine Motor	45	28.4	No	16.6
Problem solving	50	25.2	No	24.8

Phase 3
Finished SSHV input
Age 24 months:

ASQ:SE Total score = 60
Cut off scores = 50

Status: at risk

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	36.5	No	18.5
Gross Motor	60	36.0	No	24
Fine Motor	35	36.4	Yes	-1.4
Problem solving	50	32.9	No	17.1

HOME Scores Pt 22

Subscale	Score Ph 1	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2	Ph 3
Responsivity	11	11	11	0-6	7-9	10-11	U	U	U
Acceptance	8	8	8	0-4	5-6	7-8	U	U	U
Organisation	6	6	6	0-3	4-5	6	U	U	U
Learning Materials	8	8	9	0-4	5-7	8-9	U	U	U
Involvement	6	6	6	0-2	3-4	5-6	U	U	U
Variety	4	5	5	0-1	2-3	4-5	U	U	U
Total score	43								

Participant 23

Phase 1
Age 33 months

Reason for referral: financial
Service: assisted places

ASQ:SE Total score = 85
Cut off scores = 59

Status: at risk

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	35.0	No	20
Gross Motor	55	41.5	No	13.5
Fine Motor	15	29.5	Yes	-14.5
Problem solving	40	36.5	No	3.5

Phase 2/3, age 36 months

ASQ:SE Total score = 45
Cut off scores = 59

Status: OK

ASQ

Skill	Phase2/3	Cut off	Risk	Sc – cut off
Communication	45	38.7	No	6.3
Gross Motor	60	35.7	No	14.3
Fine Motor	20	30.7	Yes	-11
Problem solving	35	38.6	Yes	-4

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	4	5	0-6	7-9	10-11	L	L
Acceptance	3	5	0-4	5-6	7-8	L	M
Organisation	3	3	0-3	4-5	6	L	L
Learning Materials	6	6	0-4	5-7	8-9	M	M
Involvement	1	1	0-2	3-4	5-6	L	L
Variety	2	3	0-1	2-3	4-5	M	M
Total score	19						

Participant 24

Phase 1
Age 33 months

Reason for referral: financial
Service: assisted places

ASQ:SE Total score = 60
Cut off scores = 59

Status: at risk (marginal)

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	35.0	no	15
Gross Motor	60	41.5	no	18.5
Fine Motor	10	29.5	yes	-19.5
Problem solving	45	36.5	no	8.5

Phase 2 Age 36 months

ASQ:SE Total score = 25
Cut off scores = 59

Status: OK

ASQ

Skill	Phase2/3	Cut off	Risk	Sc – cut off
Communication	45	39	No	6
Gross Motor	45	36	No	10
Fine Motor	10	31	yes	-21
Problem solving	40	39	No (marg)	1

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	4	5	0-6	7-9	10-11	L	L
Acceptance	3	5	0-4	5-6	7-8	L	M
Organisation	3	3	0-3	4-5	6	L	L
Learning Materials	6	6	0-4	5-7	8-9	M	M
Involvement	1	1	0-2	3-4	5-6	L	L
Variety	2	3	0-1	2-3	4-5	M	M
Total score	19						

Participant 25

Phase 1
Age 27 months

Reason for referral: self
Service: Toy Library

ASQ:SE Total score = 38
Cut off scores = 50

Status = OK

ASQ (27 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	33.5	No	26.5
Gross Motor	55	35.0	No	20
Fine Motor	40.0	26.0	No	14
Problem solving	50.0	37.0	No	13

Phase 2
Age 34 months

Referral status; used toy library a few times, still going to playgroup where he accessed toy library from, using language and play service there (not SS)

ASQ:SE Total score = 40
Cut off scores = 59

Status: OK

ASQ (33 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	35	No	20
Gross Motor	60	41.5	No	18.5
Fine Motor	40	29.5	No	10.5
Problem solving	45	36.5	No	8.5

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	7	8	0-6	7-9	10-11	M	M
Acceptance	7	6	0-4	5-6	7-8	U	M
Organisation	5	5	0-3	4-5	6	M	M
Learning Materials	7	8	0-4	5-7	8-9	M	U
Involvement	3	3	0-2	3-4	5-6	M	M
Variety	4	5	0-1	2-3	4-5	U	U
Total score							

Participant 26

Age : 12 months

Reason for referral: self
Service: Toy Library

ASQ:SE Total score = 0
Cut off scores = 48 Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	16	15.8	No	0.2
Gross Motor	60	18.0	No	42
Fine Motor	55	28.4	No	26.6
Problem solving	55	25.2	No	29.8

Phase 2
Age 20 months

ASQ:SE Total score = 35
Cut off scores = 50 Status: ok

ASQ (20 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	45	36.5	No	8.5
Gross Motor	55	36.2	No	18.8
Fine Motor	45	39.8	No	5.2
Problem solving	30	29.9	No	0

Phase 3
Age 30 months

ASQ:SE Total score =
Cut off scores = 57 Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc- cut off
Communication	55	38.8	No	16.2
Gross Motor	35	30.6	No	4.4
Fine Motor	30	25.2	No	4.8
Problem solving	60	36.9	No	23.1

HOME Score

Subscale	Score Ph 1	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 3
Responsivity	10	11	0-6	7-9	10-11	U	U
Acceptance	6	8	0-4	5-6	7-8	M	U
Organisation	4	6	0-3	4-5	6	M	U
Learning Materials	8	9	0-4	5-7	8-9	U	U
Involvement	6	6	0-2	3-4	5-6	U	U
Variety	4	4	0-1	2-3	4-5	U	U
Total score	38						

Participant 27

Phase 1
Age 24 months

Reason for referral: Self
Service: toy library

ASQ:SE Total score = 20
Cut off scores = 50

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	36.5	No	23.5
Gross Motor	50	36.0	No	14
Fine Motor	35	26	No	9
Problem solving	60	37	No	23.1

Phase 2/3
Age 33 months

ASQ:SE Total score = 20
Cut off scores = 59

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	35	No	25
Gross Motor	60	41.5	No	18.5
Fine Motor	40	29.5	No	10.5
Problem solving	50	36.5	No	13.5

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	10	10	0-6	7-9	10-11	U	U
Acceptance	7	8	0-4	5-6	7-8	U	U
Organisation	6	6	0-3	4-5	6	U	U
Learning Materials	9	9	0-4	5-7	8-9	U	U
Involvement	6	6	0-2	3-4	5-6	U	U
Variety	5	5	0-1	2-3	4-5	U	U
Total score							

Participant: 28

Phase 1
Age 27 months

Reason for referral: behaviour & conc.
Service: CWC

ASQ:SE Total score = 105
Cut off scores = 57 Status: At risk

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	35	33.5	No	1.5
Gross Motor	60	35.0	No	25
Fine Motor	20	26	yes	-6
Problem solving	50	37	No	13

Phase 2
Age 31 months

ASQ:SE Total score = 70
Cut off scores = 57 Status: yes, but lower

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	38.8	No	11
Gross Motor	55	30.6	No	25
Fine Motor	30	25.2	No	5
Problem solving	30	28.9	No	1.1

HOME Score

Subscale	Score Ph 1	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	6	7	0-6	7-9	10-11	L	M
Acceptance	5	5	0-4	5-6	7-8	M	M
Organisation	3	6	0-3	4-5	6	L	U
Learning Materials	5	7	0-4	5-7	8-9	M	M
Involvement	2	5	0-2	3-4	5-6	L	U
Variety	2	2	0-1	2-3	4-5	M	M
Total score							

Participant 29

Age 48 months

Reason for referral: language and play
Service: Talkabout

ASQ:SE Total score = 30
Cut off scores = 70

Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	55	39.1	No	15.9
Gross Motor	40	32.9	No	7.1
Fine Motor	25	30	Yes	-5
Problem solving	45	35	No	10

Phase 2

Age 54 months

Reason for referral: language and play
Service: Talkabout

ASQ:SE Total score = 35
Cut off scores = 70

Status: ok

ASQ

Skill	Score	Cut off	Risk
Communication	35	50	Yes
Gross Motor	50	42.5	No
Fine Motor	40	26.5	No
Problem solving	55	33	No

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Learning materials	10	10	0-2	3-9	10-11	U	U
Language stimulation	7	7	0-4	5-6	7	U	U
Physical Environment	7	7	0-3	4-6	7	U	U
Responsivity	7	7	0-3	4-5	6-7	U	U
Academic stimulation	5	5	0-2	3-4	5	U	U
Modelling	5	3	0-1	2-3	4-5	U	M
Variety	8	8	0-4	5-7	8-9	U	U
Acceptance	4	4	0-2	3	4	U	U

Participant 30

Phase 1

Age 4.5.months

Reason for referral: Mum's dep, help c baby
Service: Counsellor and CCW

ASQ:SE Total score = 35
Cut off scores = 45

Status: OK

ASQ (4 months)

Skill	Score	Cut off	Risk	Sc– cut off
Communication	55	33.3	No	21.7
Gross Motor	40	40.1	No	0
Fine Motor	40	27.5	No	12.5
Problem solving	50	35.0	No	15

Phase 2

Age 6 months

Reason for referral: Mum's dep, help c baby
Service: Counsellor and CCW

ASQ:SE Total score = 20
Cut off scores = 45

Status: OK

ASQ (6 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	29.0	No	16.7
Gross Motor	40	19.5	No	0
Fine Motor	55	27.5	No	27.5
Problem solving	55	37.0	No	20

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	8	8	0-6	7-9	10-11	M	M
Acceptance	6	8	0-4	5-6	7-8	M	U
Organisation	5	6	0-3	4-5	6	M	U
Learning Materials	5	9	0-4	5-7	8-9	M	U
Involvement	6	6	0-2	3-4	5-6	U	U
Variety	4	5	0-1	2-3	4-5	U	U
Total score							

Participant 31

Phase 1
Age 47 months

Reason for referral: language and play
Service: Talkabout

ASQ:SE Total score = 25
Cut off scores = 70

Status: Ok

ASQ (48 mnths)

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	39.1	No	20.9
Gross Motor	50	32.9	No	17.1
Fine Motor	45	30	No	15
Problem solving	55	35	No	20

Age 54 months

Reason for referral: language and play
Service: Talkabout

ASQ:SE Total score = 5
Cut off scores = 70

Status: Ok

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	60	50	No	10
Gross Motor	60	42.5	No	17.5
Fine Motor	55	26.5	No	28.5
Problem solving	60	33	No	27

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Learning materials	6	8	0-2	3-9	10-11	M	M
Language stimulation	6	7	0-4	5-6	7	M	U
Physical Environment	7	7	0-3	4-6	7	U	U
Responsivity	5	5	0-3	4-5	6-7	M	M
Academic achievement	3	5	0-2	3-4	5	M	U
Modelling	3	4	0-1	2-3	4-5	M	U
Variety	6	6	0-4	5-7	8-9	M	M
Acceptance	4	4	0-1	2-3	4	U	U

Participant 32 ATTRITION: from service use/study

Age 10.5 months Reason for referral: Stimulation
Service: CCW

ASQ:SE Total score = 25
Cut off scores = 48 Status: OK

ASQ

Skill	Score	Cut off	Risk
Communication	25	25	On line
Gross Motor	30	17.5	No
Fine Motor	35	39	Yes
Problem solving	30	30.5	Yes

HOME Score

Subscale	Score	Lowest fourth	Middle half	Upper fourth	Position
Responsivity	2	0-6	7-9	10-11	L
Acceptance	6	0-4	5-6	7-8	M
Organisation	4	0-3	4-5	6	M
Learning Materials	3	0-4	5-7	8-9	L
Involvement	0	0-2	3-4	5-6	L
Variety	1	0-1	2-3	4-5	L
Total score	16				

Participant 33

Phase 1

Age 28 months

Reason for referral: sleep problems
Service: SSHV

ASQ:SE Total score = 25
Cut off scores = 27

Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc- cut off
Communication	60	33.5	No	26.5
Gross Motor	50	35.0	No	15
Fine Motor	35	26.0	No	9
Problem solving	40	37.0	No	3

Phase 2

Age 34 months

ASQ:SE Total score = 45
Cut off scores = 59

Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	35.0	No	15
Gross Motor	50	41.5	No	8.5
Fine Motor	45	29.5	No	15.5
Problem solving	40	36.5	No	3.5

HOME Score

Subscale	Score	Ph 2	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	9	9	0-6	7-9	10-11	M	M
Acceptance	6	7	0-4	5-6	7-8	M	U
Organisation	5	6	0-3	4-5	6	M	U
Learning Materials	8	8	0-4	5-7	8-9	U	U
Involvement	6	6	0-2	3-4	5-6	U	U
Variety	4	4	0-1	2-3	4-5	U	U
Total score							

Participant 34

Phase 1
Age 4 months

Reason for referral: Mum depression and mum having trouble with crying baby
Service: SSCCW

ASQ:SE Total score = 55
Cut off scores = 45

Status: at risk

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	35	33.3	No	2
Gross Motor	50	40.1	No	10
Fine Motor	30	28.5	No	2
Problem solving	50	35.0	No	15

Phase 2
Age 6 months

Reason for referral: Mum depression and child stimulation
Service: finished SSCCW

ASQ:SE Total score = 30
Cut off scores = 45

Status: ok

ASQ

Skill	Score	Cut off	Risk	Sc – cut off
Communication	50	29	No	11
Gross Motor	60	19.5	No	40.5
Fine Motor	60	27.5	No	32.5
Problem solving	60	37.5	No	22.5

Phase 3
Age 20 months

ASQ:SE Total score = 30
Cut off scores = 50

Status: OK

ASQ

Skill	Score	Cut off	Risk	Sc –cut off
Communication	45	36.3	No	8.5
Gross Motor	55	36.3	No	19
Fine Motor	60	39.8	No	23.5
Problem solving	40	29.9	No	6.7

HOME Score Pt 34

Subscale	Score	Ph 2	Ph 3	Lowest fourth	Middle half	Upper fourth	Position	Ph 2
Responsivity	7	10	9	0-6	7-9	10-11	M	U
Acceptance	7	8	6	0-4	5-6	7-8	U	U
Organisation	6	6	6	0-3	4-5	6	U	U
Learning Materials	8	9	8	0-4	5-7	8-9	U	U
Involvement	5	6	5	0-2	3-4	5-6	U	U
Variety	5	5	5	0-1	2-3	4-5	U	U
Total score								

Appendix 0:
Participant summaries.

Full Summary Pt 1

Sure Start Child Care Worker
Multiple developmental risk.
Pre-service poor developmental environment.
Professional referral.

Background: The family has been referred to a Sure Start Child Care Worker by their generic health visitor who is concerned about the mother's isolation and the couple's parenting skills. The family consists of a young mum of sixteen who left school while pregnant, the father an illegal immigrant, and their 12 week old son. The couple set up home together when the mother was pregnant, and they live in a small house, in one of the most deprived areas of RCT. Mum has few qualifications, had to give up a place on a college course and has lost touch with friends she used to socialise with at school. At the time of referral the family income was low: Dad worked full time, and Mum was at home.

A typical day with the baby consisted of getting the baby up, feeding him, bathing him, making bottles, doing the housework, watching television, and going to her mum's in the evening. Mum doesn't actively play with the baby. 'Going out' was limited to taking him to town on the bus, there was no other participation in local activities .

Mum is isolated: she doesn't really have any friends, although she has made contact with an old school friend who lives locally with her two children, despite this Mum doesn't go out much. Her partner works very long hours, so daily visits to her mum are her main source of socialisation. She would love to get out more now, but is reluctant to use the local mother and toddler group as she thinks girls who subjected her to bullying at school take their children there. Mum is not aware of any other activities or groups.

Experience of service use:

Beginning (Child Age 3 months) : Mum had not asked for help, the Health Visitor had suggested that she might like someone to come and help with the baby but Mum doesn't know why this was suggested, who will come or what the service consists of. When asked she said she is expecting some ideas of things to do with the baby. The family is not having any additional input from the health visitor at this time. Mum has no concerns about the baby's development but the study assessment indicates delay in his problem solving and gross motor skills.

Middle (C aged ten months): When the time came to use the service, Mum and the baby's father - her husband since their marriage shortly after the first study visit - were having to spend much time dealing family issues, it is likely the father will have to leave the country shortly. Mum and baby do not intend to accompany him. The constant travelling to see a solicitor meant the family was never in for the SSCCW visits, contact was never made and the service was withdrawn. Mum would like another opportunity so use the service, but will not contact Sure Start and ask for it because she is shy. Mum has no

concerns about the baby's development, and the research developmental assessment identified no areas of concern.

Since the last visit there have been some changes for the family. The grandmother's marriage has broken up, and grandma has had to get a job. This has increased Mum's isolation as the daily visits have ceased. Apart from this, Mum has a contact with another friend but says she does not see very much of them. The day is still mostly home based with no community involvement or outside play. The child has lots of toys within the house, but Mum does not appear to direct or supervise his play, or show any awareness of how to promote his development. Mum describes life as a struggle, and is expecting to have to get a job soon as her husband is now unable to work.

Ending (C 24 months): Mum and C are now living together alone as father was deported six months ago, and it is likely to be a couple of years before he can return legally. The grandmother has a new partner and is moving to another part of RCT. Mum is also arranging a move to be in the same area as her mother, but in her own house. The move will involve other changes as Mum has enrolled in a local college to do an access course. C will go to the college crèche while Mum studies. Mum also hopes she will make new friends, and do more in the community. She still has not used the play group over here, because C has no routine in his day and this means he sleeps late in the morning and is not up for play group times. Mum has not heard of any other local activities. Her day is still mostly at home, and she is even more isolated now - she sees no one at the moment, her husband is away, her mother works, her sister is always out at school or with friends and one of Mum's friends has moved away while the other has begun using drug, and is therefore avoided.

Since the last visit Mum has started using the Sure Start Child Care Worker service. At a health clinic visit the Health Visitor mentioned the service again and asked if she was interested. Mum says she feels she would like the input for herself and for the baby. She feels she needs help, she is concerned because the child's behaviour is poor - he has lots of tantrums, and he won't share his toys. She feels the service will help him, although she has found the sessions a bit difficult so far. The developmental assessments indicate delays in social, emotional, communication and motor skills.

Full Summary pt 2

Sure Start Child Care Worker.
Multiple developmental risk.
Pre-service poor developmental environment.
Professional referral.

Background; The family has been referred to a Sure Start Child Care Worker by their generic health visitor who is concerned about the mother's isolation and the couple's parenting skills. The family is of a young unmarried couple who set up home together just before their son was born twelve weeks ago. They live in a terraced house in a deprived area of RCT, near to the paternal grandparents. Dad works full time and Mum is a full time young mother aged 16 years old. Mum is very close to her own family and has been missing them since she left the family home. She also suffered a family bereavement recently.

A typical day consists of Mum getting up when the baby wakes at about 9.30 a.m. this is after her partner, has gone to work. Much of the day is spent watching television. She does not actively play with the baby who does not have many toys yet. In the evenings when her partner is home he usually has the baby while Mum cooks supper. Mum said she doesn't go out much in the day as she is new to the area, doesn't know where things are, and has only one friend in the area. Her partner works very long hours and seldom has a day off. Outside of the house she sometimes walks to the town a few miles away but finds this very tiring. Using the local buses for transport is a problem as the pram they have is too big to get on board. At weekends she takes the train to see her family and spends the day with them before her father brings them home in the car.

Experience of service use:
Beginning: The generic health visitor had suggested the SSCCW as she was concerned about Mum's isolation and lack of stimulation for the baby. Mum had not asked for help, and thought the service had been suggested because the baby was her first. She had no idea what the service would be like but assumed it was help with the baby. Mum sounded unenthusiastic about the Sure Start home visiting service as she had found the constant home visits of the midwife irritating. Mum has no concerns. Research assessment indicated his problem solving skills were delayed.

Middle/ End. By the time service use began, Mum had started to get out a bit more. She had received two visits from the SSCCW, but after that was not home when the SSCCW called and the service was eventually withdrawn. Mum was not keen to have a second visit from the research team and was out for two arranged visits. On the phone when arranging the visits said she was too busy for the service, although she described it as 'OK', and she had no concerns for her child.

Pt 3 Full Summary.

Sure Start Counsellor.
Low developmental risk.
Pre-service use moderate developmental environment.
Referral direct parental request.

Background: Mum had been referred to the Sure Start Counsellor after her partner had contacted the generic health visitor asking for some help with Mums post natal depression. The family are a non married couple and their eleven month old son. They live in a small terraced house in a village in a deprived area on the outskirts of a large valley town. Dad works full time, Mum used to work but has been a full time mother since the baby was born. They see both extended families regularly. Mum feels isolated at the moment, she did see one friend who had a baby, but this friend has gone back to work. Mum feels she is too busy to see people much anyway.

A typical day consists of Mum getting up, dressing and feeding the child, and then she puts him in the front room to play with his toys. Later in the morning they usually walk

into town. They stop in a shop to see grandma who works there, and do a bit of shopping. They then come home for lunch, watch television for half an hour, and then he has a nap, while mum does a bit of housework and phones a friend for a chat. In the afternoon he plays with his toys again. Mum has tried reading to him but has found him restless. Later in the day they sometimes walk to the supermarket or to see his dad at work. Dad comes home after work and plays a lot with the child. Mum cooks tea and they all have tea together. The baby then has another nap after which his dad gives him his bath, he goes to sleep about 8 o'clock.

Experience of service use:
Beginning: Mum had been feeling very depressed since shortly after the birth, she feels she has post natal depression. This has become such a concern that her partner rang their generic Health Visitor to ask for help, and a referral to the SS counsellor had been offered. Mum is to begin sessions in the next couple of weeks, and just wants to feel better. The family have no concerns for their baby. The research assessment indicates his problem solving skills are delayed.

Middle: Experience: Shortly after the first study visit, the counsellor sent Mum a letter and arranged a time for the appointment at the hospital. The paternal grandmother looked after the child during the sessions. Mum drove to the sessions which lasted for twelve weeks. Counselling ended when the counsellor asked if mum wanted to continue sessions and Mum felt she had had enough as she as feeling fine. Mum was invited to ring if she wanted to resume sessions. Mum felt the counsellor was lovely, but she hadn't known what to expect and before the first session she felt very nervous. After her first visit - although she still often found it hard to go to the appointments – she realised she could cope with them, and felt the work they were doing was helping her.
Perceived outcome: Mum feels the sessions have helped her become more patient and have encouraged her to go out more to activities. Mum now goes to a local playgroup three times week with a friend. Mum feels this is helping the child's social skills i.e. learning to get on with other children as he was a bit of a bully at the beginning but better now. Mum has no real concerns. The research assessment indicates his problem solving and fine motor skills are delayed.

There have been some changes in the family Mum's relationship with her partner has been of concern and the counsellor gave her a number for 'Relate' but Mum has not tried to make contact yet. The paternal grandparents have split up, which means he does not see them much, and the father has been quite upset.

Ending: They still go up to the Meithrin twice a week and love it. The swimming she had started going to - on the advice of the counsellor – has stopped as the pool is being refurbished, but will start again when it re-opens. There are no other local activities for families children Mum can think of, and she as heard of no other Sure Start activities. Mum does more with the child at home. Looking back at the counselling sessions Mum feels she was a bit nervous at first but now she doesn't know what she would have done without it as it really helped. In the end she attended sessions off and on for the best part of a year. They helped her think of things to do with her child, increased her patience with him, and helped her to cope when she got stressed with him. Mum feels these improvements have remained since she finished her counselling sessions. Research assessments indicate no developmental delays.

There have been other changes in the family. The couple did not use the Relate referral but are OK now. Mum has started to work a little as her mother has begun a new business and she goes up to help while her Mum has the child. Her partner has also given up his job and started a garage business by himself, which may lead to Mum getting involved in the administration soon – it also means he gets home earlier and plays with more.

Full Summary Pt 4.

Sure Start Child Care Worker.
Low developmental risk.
Good developmental environment.
Professional referral.

Background: The family has been referred to the SSCCW because the generic health visitor was concerned about X's speech. The family is a married couple with two sons, one aged fifteen and X. who was twenty four months old. They live in a terraced house in town in RCT. Dad works full time locally, and Mum works night shifts part time and looks after X during the day.

A typical day consists of X waking in his cot which is in the same room as his parents. He wakes his mum who takes him downstairs and feeds him his breakfast as he watches television. After breakfast, X watches television and plays with his toys while mum does the cleaning. He is dressed about nine o'clock, in time for them both to go to a mother and toddler group by ten. On days without mother and toddler they sometimes go and see his maternal grandmother, or stay home and play.
After playgroup, at about eleven, X. has a sleep. If Mum has been working they go to bed together for about 3 hours, otherwise he sleeps by himself for about an hour. It is then lunch time, for which X sits in a chair in the sitting room. After lunch Mum and X may play together again, or they may go out to activities such as the local swimming pool. Later on his brother comes home from school and plays with his little brother, often football, while their mum does some housework. Dad comes home around half past four and takes X for a walk or does something with him. They often go to see his paternal grandmother, L likes this. He loves to watch trains.
After his time with his dad, he has his supper, and Mum then baths him before bed. He then has a little play and goes to bed, with his strawberry milk, and watches a video in his bedroom until he drops off to sleep.

Experience of service use:
Beginning (aged 24 months) : The generic Health Visitor had been concerned about X's speech and had suggested a referral to the Sure Start Child Care Worker and to a speech therapist. Mum had been quite happy about X's development, had felt he was developing well and was very bright. However, as she felt parents should do anything to help their children, she is happy about the proposed interventions and intends to take him to the speech therapist as recommended. In the meantime she feels the Sure Start service should help while they wait for the therapist appointment, although she did not know what form the service will take. Assessment indicated X's communication skills were delayed.

Middle (X aged 33 months): Experience: Service use began with telephone contact from the Sure Start Child Care Worker, during which the worker asked about things Mum and X already did together and so was able to arrive at the first visit with a bag full of toys suited to L's abilities. She came for 12 weeks, and engaged in activities such as puzzles and painting, during which she would work on X's communication skills by getting him to repeat and pronounce words properly. Mum sat in on all the sessions, and loved watching them working together.
Perceived outcome: Mum felt the service had improved X.'s speech, she could understand him a lot better afterwards and thought X was talking a lot more. She also felt the service had an effect on the families' interaction with X. as they now took trouble with everything they did with him to bring him on, i.e. to help his development. When they attended the speech therapist appointment which took place after the SSCCW had finished, the speech therapist felt there was no problem, but proposed a later visit to allow monitoring of X's communication, Mum was happy with this. The family has used other Sure Start services, their SSCCW told them about the baby gym which they have begun attending, and about the Sure Start Christmas fair which they went to. Mum believes she would not have known about these services if she had not been using the SSCCW service. Research assessment indicated X's communication skills were now competent.

Follow up (X aged 39 months): In the final visit six months after service use finished, the family moved house, but otherwise their days and routines had not changed. Mum confirmed that his speech has become more understandable and continued to develop – e.g. he is now using sentences, which he had not been doing at the time of the last study visit. The improved family interaction - contributed to the service use by Mum - has continued, the parents still take time to help his pronunciation. X. has been taken back to the speech therapist to check his speech and has now been discharged from that service. Mum felt overall that the Sure start service had helped immensely but the speech therapy appointments had not. Mum has recommended the service to a number of friends. No additional services had been heard of or used. X's parents have no concerns about him at this moment. Assessment indicated X's communication continues to improve, all his ASQ scores were maximum values.

<u>Participants 5& 6</u>
Next Steps.
Low developmental risk.
Preservice good developmental environment.
Self referral.

Background: The mother and children of the family have just begun attending a group which gives adult education classes while children are looked after in an attached crèche/nursery. The family is a married couple in their thirties with their twin sons aged thirty two months old. They have just moved into a house on a housing estate in a non deprived area of RCT. Dad, who is disabled works full time and Mum is a full time mother.

A typical day consists of the boy waking up, in their own bedroom, and coming into their parents bed at around half past five. Dad gets up with them, brings them downstairs and gives them breakfast if they are hungry. Mum gets up when Dad goes to work, about 7

o'clock. She gets dressed and then takes the boys upstairs, dresses them and brushes their teeth. Their morning involves a lot of playing with their toys, with one another, and mum spends a lot of time playing with them often using toys with a developmental purpose. The boys also 'help' with household chores they particularly like washing up! Sometimes they go for walks, to her mums.
They have lunch in the kitchen in their highchairs, then about one o'clock, they go for a sleep. Mum uses this time to tidy up and sometimes a friend calls, although Mum does nor have many local friends yet. When the boys wake they have an early tea and then daddy comes home between five and six. Dad showers while the boys have their bath, then they come down and Dad plays with them, usually play fighting or puzzles and mum is encouraging dad to read to them. Then they have supper, the parents eat with them and attempt to have a family meal.
The boys go to bed about 10.Mum has problems getting them to sleep as they sleep together, and get out of bed and chat a lot.

Experience of service use.
Beginning: Mum recently found out about Next Steps from a friend. She wishes she had known about it earlier because she has been on her own a lot, and feels she received little support from family, midwives or health visitors since she had the twins. She would have loved to have used the service before, especially since she found out that a minibus used to be provided for service users which would have helped her problem of transporting small twins, which made getting out of the house difficult and meant didn't get out much.

Experience of service use: Mum has been able to use Next Steps for about eighteen months. There are two sessions a week at the centre they go to, but as one is relatively short so the family go once a week to a four hour session Mum and the boys love going. The boys are in one room in a crèche with other children. Mum feels the nursery is very well run, with a structures routine and many diverse activities, while Mum is next door with other mothers doing different craft activities, such as card making. Recently service users decided the parents and children should do some combined activities and they are presently doing a lot of modelling activities with the children.

Outcome: Mum feels the boys are profiting because they love the interaction with other children, and they get the opportunity to do different activities. This is important at the moment as she started the boys at the local playgroup but they didn't settle and became increasingly upset about going, so Mum stopped taking them. For herself Mum feels she learns from the boys activities as she can take them home, and they are things she wouldn't have thought of by herself. Mum also feels the service is important for her because she gets the chance to get out, to socialise and she enjoys the type of activities they do.

Follow up: The family are still using Next Steps, in fact they are using it five times week, at different locations. The boys go to them all still, but are not getting contact with others their age now as their peers have begun school. However now the boys are that bit older there are three boys up the road they spend a lot of time with. Mum feels the nursery nurses are very good in the Next Steps groups and they bring in stuff for the boys at a slightly older age

Mum has not heard of any other SS services since last time, but overall she feels her experience of SS has been fantastic. For herself and the boys, both for activities, stimulation and socialising which is important as she feels there is nothing in their areas for mothers and children.

Participant 7

Sure Start Child Care Worker.
Low developmental risk.
Moderate developmental environment.
Professional referral .

Background. The family had been referred to Sure Start Child Care Worker as the generic Health Visitor was concerned about X's communication skills. The family are a couple in a long term relationship and their daughter who is twenty-seven months old. They live in a terraced house in a deprived area of RCT. Both parents work full time, and X is looked after at her grand-parents house during the day.

A typical day begins with X. waking up in her mum's bed. X. has her own bedroom, but when ill recently she became used to sleeping with her mum, and now if sleeping alone she wakes very early and wants to get up, so at present she sleeps with her parents. When they wake they come downstairs and have breakfast together, sitting in the sitting room with X on her Mum's lap. Dad is sometimes around and sometimes had gone to work. After breakfast X watches television while mum gets herself ready for work, gets X's bag ready, loads up the car and then takes X. up to her grandparents. They usually came to the door to say 'bye' to mum. They then do puzzles and blocks, watch a bit of television, or X will draw or play with her play-doh. She then has a long sleep usually about for 2 hours, afterwards which they have lunch together. Grandpa often then takes her out to walk, or go to a nearby park.
Mum picks her up about 3.15 pm, sometimes they go to the supermarket and then they go back home where mum prepares tea, which they eat as a family around 5 o'clock when dad is usually home. The parents clear up, and X likes to help by taking things to the kitchen, she also likes to help with the housework – to have a duster and use the mop or Hoover. Mum feels she should do more with X, should leave the housework and sit and do more things with her. X's dad is very good with her, they enjoy 'rough play' together. After tea the family sometimes go into the garden or go for a walk. They also try to do things - such as puzzles - with X, but Mum feels X doesn't really want to just now. Dad baths X if he is home, this is something X enjoys when she had a bath she never wants to get out! Bedtime always includes a bed time story and getting all her dolls in bed with her

Experience of service use:
Beginning (24 months) : The referral came because the generic Health Visitor was concerned about X's speech. Mum had not been concerned but agreed to see the SSCCW and to a referral to a speech therapist. Mum hadn't heard of this Sure Start service before, the leaflet given her in the recent initial contact visit had been the first she knew of the other agency services. Mum hopes the work of the SSCCW would improve X's communication and concentration skills, but wasn't sure X's speech needed help as it was

improving on its own. Assessment indicated that X's communication and problem solving skills were delayed.

Middle (28 months): Experience: During service provision the SSCCW worker came one hour a week for eight weeks. Sometimes X got fed up concentrating, which Mum felt was because the service was at a time X had just got home after being away all day and therefore was not in the best mood to get involved. Mum watched all the sessions but only got involved if X. wanted her to. The worker rang before the first session to ask about the activities and skills X already could do, and then brought a variety of activities to work with.
Perceived outcome: Mum feels the service had been worth having, and that X's speech had improved since the service provision began, although she is still not very talkative. She felt the improvement was also associated with use of a new play group X attended, and the fact X is now older. Mum thinks X enjoyed the service, but she herself was anxious, worrying whether something was wrong with X. and only used it as she wanted to be sure there as nothing wrong. Mum thought the service had changed the way she interacts with X, and she now puts half an hour aside to spend with her, doing puzzles, to play with her little computer and doing action songs. X's Dad feels it has all been a fuss about nothing. Assessment indicated X's communication and problem solving skills were still delayed but had improved since the last assessment.

Full Summary pt 8.

Sure Start Child Care Worker.
Multiple developmental risk.
Pre-service poor developmental environment.
Indirect parental request.

Background: The family had been referred to a Sure Start Child Care Worker after Mum mentioned her concerns about X's behaviour to her generic health visitor. The family consists of a young, single full time mother with two sons, one aged seven years old and J who is twenty eight months old. They live in a small semidetached house in a run down area of a poor estate. Mum left school before the statutory leaving age when she became pregnant with her eldest son, as when she returned to school after the birth she was put in lower level classes. This frustrated and upset her so she left after taking one GCSE. She feels she would like to return to education at some time, but life is hard at the moment; she is suffering from depression, and finding the boys - particularly X. - difficult. The boy's parents are separated; their father is currently unemployed, uses drugs and has mental health problems. X sees his father every couple of weeks, and his brother stays with their Dad some weekends and for longer periods during school holidays.

A typical day begins with X in his Mums bed, he often sleeps with his Mum. Mum usually wakes first, and then they come downstairs and have breakfast. X. then dresses himself, and his brother leaves for school. In the mornings Mum often takes X to the swings across the road, and she usually sees people she knows there. Sometimes they go down to town in the morning, either by bus or she walks down with him. X. walks lots of places, as he is a very physical little boy who hates the pushchair. They use the shops to get food and they always get the bus home as the walk home is very steep, and the buses are good they run every half hour. When they come back home X puts on the television

or the play-station, or he goes out to the front of the house to play with a little neighbour. X. doesn't usually have a sleep in the day, Mum says it is hard to get him to have a nap because children are through the house all the time. They have lunch and afterwards X watches the television or plays with the play-station, until his brother (N) comes home and takes the play station to his room out of X's way. In the evenings X. follows his brother round, but his brother doesn't want him round at the moment as X. is swearing a lot, biting, spitting and hitting. The boys have a bath together about seven, they usually fight in it, N often goes out again after but X puts on his pyjamas, has supper and snuggles up on the sofa and falls asleep.
Mum feels the fun bit of being a parent gets lost in routine and hassles at the moment.

Beginning (28months): Mum felt X was becoming increasingly aggressive, he is biting and attacking other people including his grandmother who is now a little reluctant to visit as much. Mum mentioned these concerns to her generic Health Visitor when she saw her, and a referral to Sure Start was suggested. Mum has no idea what form the service will take but hopes it will improve X's behaviour. Research assessment indicated X's socio-emotional and problem solving skills are delayed.

Middle (34 months): Experience: The SSCCW contacted mum and they arranged a mutually convenient time. The worker came once a week for six weeks and spent about an hour and a half each time at the home. Sessions involved a bag full of toys, puzzles, drawing and painting materials which the worker used to played with X, initially to see 'how advanced he was'. Mum sat in on the sessions and the worker talked to her during the sessions. X enjoyed the sessions, he looked forward to the sessions, and his favourite thing was a threading toy.
Perceived outcome: Mum could not think of any changes that had occurred in X, during the time of the sessions, but when pressed she admitted he became more confident over the time of the sessions, and commented that his speech had improved recently. He is not biting now, but he is swearing more and his violent behaviour (hitting) remains. Mum felt she had not learnt anything from the sessions, and her experience of the service had not led to any changes in X's day's, or in her interaction with him. Advice about potty training was given and that had been very useful, Mum said the worker would be welcome any time. Mum said she had not taken part in, or been made aware of any other Sure Start services. Research assessments indicated X's problem solving skills are no longer delayed, but his socio:emotional skills are still delayed and his fine motor skills have become delayed

Later follow up:
Mum says she is finding life easier at the moment, she is in a new relationship and pregnant. Mum is very concerned about the increasingly bad behaviour of her elder son at home, she thinks he resents her new relationship. Nothing much has changed for X, his days are much the same, although he begins school soon. He does not bite so much now but still swears and kicks a lot. No other activities have been found or suggested. Mum sometimes finds it all a bit much. Research assessment indicates all his developmental skills (communication, gross and fine motor and problem solving) are hovering around the competence cut off line (2 to – 1.5) , while his socio: emotional skills are still delayed.

Full Summary Pt 9. (field notes)

SSCCW.
Low developmental risk.
Moderate developmental environment.
professional referral;

Background: The family has been referred to the SSCCW by their generic health Visitor who is concerned about X's speech . the family consists of X., a twenty- six month old little girl who lives with her grandmother and teenage aunts and uncle. Her young mother has left X. with her grandmother since the birth. Mum does return home from time to time for a couple of weeks, but X does not see her father who is a young man with a history of violence and drug abuse. Grandmother is now X's full time principal carer and X gets a lot of adult attention from grandma and from her aunts and uncle. The family live in a large, terraced house, in a town in RCT. No one in the house is employed, the older children are in school or on benefits.

X's typical day is home based. Books and toys in the home are really evident and grandma says she has time to sit and read/play with X. Grandma looks after X one day and then her 18 year old aunt looks after her the next. All child care and play comes from within the house. Her day seems to consist of playing with her toys, watching television and going into town, which is within walking distance. Grandma plans to send her nursery soon.

Experience of service use:
Beginning (26 months); The generic health visitor has referred X. to a SSCCW as she was concerned about X's little use of language. Grandma hopes the service may help X speak a little more, but she herself is not very concerned as she feels X understands a lot of what is said to her, and that her speech is picking up at the moment. Grandma feels it is possible X does not feel she has to use speech as the family anticipates her needs and requests so she doesn't have to ask for them. Grandma had not been aware of Sure Start services before this, but was quite positive about accepting the offer of a service as she could see no reason anyone would not want to. Research assessment indicated X's speech was delayed and her gross motor skills were borderline.

Experience: The SSCCW worker came one hour a week for six weeks. Grandma took part in the sessions when X. wanted her to. The worker rang before the first session to ask about the activities and skills C already could do, and then brought a variety of activities to work with.
Perceived outcome: Grandma feels the service had been worth having, and that X's speech had improved since the service provision began but she is still not very talkative. X enjoyed the service, but she herself was still not sure she really needed it. The service had not changed the way she interacts with X, as she still finds time an issue and looking after all the family very tiring. Assessment indicated X's communication and problem solving skills were still delayed but had improved since the last assessment.

Full summary Pt 10.
Sure Start Child Care Worker
Direct parental request.

Moderate pre-service developmental environment.

Background: Referred to the SSCCW service. The family is a couple in a long-term relationship and their twenty eight month old son X. They all live in a well decorated, well cared for large three bedroom terraced house, in a good area of a deprived town. Dad works full time and Mum is a full time mother.

Typical day:
X. is a two year old boy. In a typical day he wakes about 7 o'clock in his own bedroom, and comes into his parent's room. Dad takes him downstairs. In the mornings, after Dad goes to work, Mum makes sure X has his breakfast as he is a 'fussy' eater. He has his bath and then they go to a playgroup. This is a little way off as mum does not know many people locally, but this group is closing soon and their intention is to go along to a nearer one with a friend then. If there is no play group, the morning may be spent at local toddler play activities, with friends, or - once a week - shopping in Cardiff. X. has a sleep after playgroup, and then eats his lunch by himself sitting in a chair in the sitting room. In the afternoon they may go for a walk, or X plays with his toys, usually by himself as he doesn't like sharing his toys. His toys are in his room, if he wants to play with his toys he plays in his room or visit his room to bring toys down. If mum plays with him she does as he says or he hXs a tantrum.
In the evening H eats his evening meal sitting in the chair, and spends some time playing with Dad before Dad gives him his evening bath and then it is bed

Beginning: Mum was concerned about X's behaviour. She felt X. was unable to settle to anything and lacked concentration. He had tantrums if he couldn't get what he wanted and Mum is worried that when he begins school next year he will have difficulty settling in and will not benefit from his school education. She fears X. may suffer from an attention deficiency disorder. Mum contacted her Health visitor and asked for some help and was referred to a SSCCW. Mum has been told the SSCCW will come to the house and will work with X, using activities that will help him be quieter, less active and more able to take part in activities, puzzles and games. Mum is looking forward to the service, she hopes it will help X.. Research assessment showed X's socio:emotional skills are delayed

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Middle: Experience: Mum received a letter from her SSCCW, followed by a phone call to arrange the sessions. The SSCCW came once a week for 8 weeks, she brought and played with toys and books, and would move him on to new things if he was getting bored. They did some maths and some matching and X appeared to really enjoy it. Mum sat in on all the sessions and joined in where appropriate.
Perceived outcome: Mum was impressed with the service, and she feels it helped her relationship with X., She now knew how to interact with him, was able to sit down and play with him, and knew how to deal with difficult behaviour such as his tantrums. This has meant Mum is able to cope with his difficult behaviours and does not get so upset by them. X's behaviour had improved and Mum is no longer worried he had ADHS. Mum has recommended the service to friends. Mum did learn about another Sure Start service from her SSCCW but doesn't use it as getting there is too hard as she doesn't drive. Mum has no concerns about X, and research assessments show he has no developmental delays, although his socio:emotional skills are close to the competence line.

Later situation: Six months after service; Mum felt X's behaviour is still better than it was before service use. Mum is still able to sit and play with X and the family still use techniques learnt from the SSCCW to deal with difficult behaviours. Mum is still finding it easier to cope with any bad behaviour. Mum also feels she has become more involved and a bit more relaxed about the mess he makes. Overall Mum feels the service has had a lasting effect mostly demonstrated by X's better behaviour. X. is about to start school next week and Mum said she had no real worries about this. Mum has no concerns about X, and research assessments show he has no developmental delays, although his socio:emotional skills are close to the competence line.

Full summary Pt 11
Mother and Toddler group.
Pre-service moderate developmental environment.
Low developmental risk

Background: Mother and son are just beginning use of a Sure Start Mother and Toddler group. The family is a couple in a long term relationship who have a thirteen month old son X. and they live together in a small terraced house on the main road through a village in a deprived area of the county. Dad works full time and Mum works part time. X. is looked after by his grandmother when Mum is at work.

A typical day often begins with X waking up in his parents bed around seven o'clock, even though he begins the night in his own bed. X. wakes first, then he and Mum come downstairs for X to play and watch television while Mum gets his breakfast ready. Mum feeds him his breakfast in front of the television when it is ready. If it is a day when Mum is working, she dresses X and then takes him up to her mother who looks after X while Mum works. Mum is not sure what X does at his grandmothers, but when at home he plays with his toys, preferably physical toys, such as balls or his toy car. He mainly plays by himself - he has plenty of toys and books, although Dad plays with him before and after work. On working days Mum picks X. up about five o'clock and takes him up to her grandmothers where he plays with Mum's cousins. They come home about seven o'clock, X has his bath with all his toys in and then comes downstairs for a little play. At bed time he is put to bed and settles himself to sleep.

Mum felt the role of parents was just to be around, to feed them...., she said she didn't really know.

Experience of service use:
Beginning: Mum can't remember how she found out about the mother and toddler group, but thinks it was either through her health visitor or an aunt, - probably through her aunt because she to go up to the same group. Mum feels there is not much else around their area for young children X's age, although there is a 'pop in' mother and toddler group in the next village. She chose her group because she feels it is a local service, others in her family have used it, and it has a good reputation. Mum is hoping X will benefit educationally and socially through the activities and through interacting with the other

children. She also feels she will enjoy the social aspect of attending the group but feels that is not the point of going.

Family failed to respond to attempts to collect further data.

Full summary Pt 12.

Self referral
Mother and Toddler group.
Low developmental risk
Moderate pre-service use developmental environment.

Background: Mum and X are just beginning to use a local Sure Start mother and toddler group. The family consists of a married couple with two daughters, B. who is twelve and attends a local comprehensive school and X who is 13 months old. Mum had severe PND after her first daughter's birth, X is an unplanned 'late addition' as Mum was never keen to add to the family as she feared the PND may return, indeed is not sure she ever got over it. The family lives in a small terraced house in a deprived area of RCT. Dad works full time, and Mum is a full time mother, all the family live close.

A typical day begins with X waking up and having breakfast with her sister, this is a good meal for X compared to the rest of the day, as she is a 'picky eater'. After breakfast mum helps X dress, and then they often go down to the local shops, or go out and visit friends. X watches about thirty minutes television in the morning or looks at books or plays with her toys. Mum plays with her for some of the time but feels X is very good amusing herself. Around midday X has a half hours sleep. In the after noon they tend to stay home, and when X's sister comes home from school she spends a little time playing with X before going out to play with her own friends. Dad is always home before X's bedtime, and they all eat together if he is back in time. When dad gets home he plays with X before she has a bath with her sister. After this X reads books with Dad. At bed time X has a bottle of milk and goes to bed where she settles herself to sleep.

Beginning: Mum and X have just made their first visit to a Sure Start mother and Toddler group. Mum is local, knows the area well and feels it is pretty easy to find things around this area. She knew about the mother and toddler because it is well advertised, and her sister used it with her own children. She feels the group is good and hopes the services will allow her daughter to mix more and play with others, and allow her daughter to get used to being with other children her own age, and she may well send X to the nursery in the same building mother and toddler group before she goes to school. Mum feels it is also a place for her to do a little socialising.

Middle/ending; X is still attending the Mother and toddler group and also goes up to the 'Link up' (pre school experience of receptionschool) group at the school she begins in a couple of weeks, and to a SS play group at the centre the mother and toddler is at, she attends that four times a week and loves it. They spend time on art activities e.g.

sticking, messy play, singing, and have snack time where they all sit down together at a table.
Outcome: her social skills have really come on, the other children are really important to her. and Mum feels her speech improved dramatically when she went there. Their elder daughter went there as well so Mum knew about it all the time, and always found it very good. X has also accessed another SS activity at the group, a literacy programme, making things, messy play, which went on for about 6 weeks. Mum feels X really enjoyed the group and the getting to know other children.When asked about her feelings Mum said she was fine, and is doing a lot of jigsaws and chatting with X now.

Full summary Pt 14

Self referral
Baby gym/massage.
Low developmental risk.
Good developmental environment.

Background: Mother and daughter have just begun use of baby massage sessions. The family is a married couple with an elder son and X. their twelve week old baby daughter. Dad works full time and Mum as a full time mother. X is a very much wanted baby; her parents were having difficulty conceiving a second child, and were in the process of becoming adoptive parents when X was conceived. They have an elder son and had always done a lot of activities with him when he was a toddler. The family live in a large terraced house in a good area of a deprived village in RCT.

A typical day begins when Mum hears X playing in her cot after she wakes, they use a baby mobile for this. Mum brings her downstairs, washes her and gives her breakfast. She is dressed after breakfast, and then she plays on her blanket, she has a baby 'gym' and other toys that have lights and music. Mum sits with her as much as possible when she is playing and talks to her all the time as she feels it is very important. Then X. has a 2 hour sleep, before lunch. They often go out for walks in the buggy, but sometimes they wait until the elder son is home from school. X. has another 2 hour sleep in the afternoon. When her brother is home from school, mum takes him to many activities (e.g. karate, swimming) and X goes along too. When they get back home X. has her supper, usually home cooked and puréed food, before she has a bath with Mum. She is put to bed around half eight and sleeps through. many family members live in the same road and family and friends call every day.
Mum feels the role of parents is to give them lots of attention, change nappies, feed them, get to know them. Parents should also help children get a lot of different experiences.

Service use experience:
Beginning: Since she had her first child Mum has always used a lot of local activities and feels her area is well provided. She visits the health clinic regularly and learns of many local facilities there. It was during a clinic visit Mum heard about baby massage and a swimming group from her Health Visitor and was keen to try the massage as she feels it will promote her bonding with her daughter and that they will both enjoy it. Mum loves doing things with the baby, as long as it fits in with the baby's routine.

Family failed to respond to attempts to collect later data

Full Summary Pt 15

Self referral
Baby gym/massage.
Low developmental risk family.
Pre-service use moderate developmental environment.

Back ground: Mother and daughter had just begun to use Sure Start baby gym/massage service. The family is a married couple with four children, a daughter in sixth form, two sons in primary school and X., a new baby daughter. The family has recently moved into the country, neither Mum nor Dad are British. Mum feels life in the UK is much better than their life in her home country. They have bought a house in a deprived area of RCT, and live there with their children. Mum is quite isolated she does not have many friends in the neighbourhood, their social life is mainly through their church. Mum is not encouraging the children to use the local children's group as they are being bullied at school. Dad works full time and Mum is on maternity leave from her part time job, a job to which she returns soon.

A typical day: X sleeps with mum, and feeds as she needs through the night. When X wakes up and fills her nappy, Mum knows the day has started and gets up gives her a bath and sees the kids off to school. If X goes back to sleep mum may get another hours sleep then. Mum says X sleeps and eats throughout the day, and she gets a bit bored as she feels there is not much for her to do until the children come back from school, so she often fills her day by reading. She tries to encourage the children to read at home but feels they are not interested yet. Mum does not get out much in the community but does get out of the house to go for walks during the day, and now will have the yoga on a Friday. When the children come home from school the family do all the chores together, and then the children are free to play and watch television Mum talks to the children a lot, she feels it is important. When she begins work again the elder children will take care of the baby in the evenings.

Experience of service use:
Beginning: Mum saw the Health Visitor putting up a notice about the baby yoga group when she was at the baby clinic, and she asked about it. She has started using it as it gives her something to do, and somewhere to go outside of the house. She had to catch a bus to the group, which was a problem because the bus she needed doesn't start running early enough. Mum has no concerns for the baby, she feeds her as needed and otherwise the bay sleeps most of the time. The research assessment indicates she has gross, fine motor and problem solving developmental problems

Experience of service use: Mother and C used SS services at the Leisure centre for approximately one year -from the time of the last visit until they went to Mum'S home country for a visit last November. X. loved the massage, sessions involved taking their clothes off as the massaging is total, the mums hold the baby, take their pampers off and wrap them in towels, and lie them on the mat. the process starts from the back, the massager gradually takes oil and rub their feet, gradually. Mum loved it too as she learnt how to massage.

Perceived outcome; relaxing for X, Mum feels babies do feel relaxed when you do it like that. Mum also feels swimming is the same, when they come home after either X. sleeps really well which Mum loves because it gives her a rest for the rest of the day.
It also gave her something to do, but using the service has not helped find other things to do. At work someone told Mum about a mother and toddler local group which she has now been to once. The family still does not go out much, Mum still is not aware of many activities, and only sees the health centre staff when a child is sick or it is time for immunisations. The day is still centred round the home. X. loves the television and likes to dance to the music on screen and watch videos, she also loves being with her siblings when they come home. In the afternoons Mum often takes X to the fields for some fresh air. Mum now works from 5 pm til midnight and the older children look after X. mum is still aware of experiencing racial abuse – now it work based, although she thinks the children are OK. Mum is not concerned about X. Research assessments indicate she has a communication delay and her fine motor skills are on the competence line.

Full summary Pt 16

Self referral
Mother and Toddler.
Low developmental risk.
Pre-service moderate developmental environment.

Background: Son is about to taken to a Sure Start Mother and Toddler group. The family is a married couple with two daughters at primary school and a son X. who is ten months old. They live in a terraced house in a large town in RCT and are about to move to a modern detached house in a estate a few miles outside of the town. Dad works full time and Mum works part time before and after school times.

In a typical day X gets up early and has his bottle as soon as he wakes. Sometimes he will sleep longer and Mum leaves him for his Dad to organise. Dad gets up when Mum goes to work and his maternal grandmother arrives to take over when Dad leaves for work. During this time X plays with his toys. He has a big box of toys, he loves push along cars, and has music toys, rocking toys but is not into books yet. He has a nap around nine o'clock, during which Mum comes back from work. When X wakes, Mum gets him dressed and he plays with his toys while mum cleans up. He has lunch about eleven o'clock, usually homemade purees, and then he will play with his toys and when she has time Mum will sit and play with him. Then they usually go to town or go shopping, this has to be done daily because Mum organises the food for work. X likes being out and about, so she will take him to friends houses and he goes to another mother and toddler in town with mum once a week. When Mum works X is looked after at a friends house each afternoon, and is there from two thirty until Dad comes home about five forty-five. The family eat together when they are all in, although X has often already eaten. X has a bath every other night, which he loves, has supper around seven and goes to bed.

Experience of service use:
Beginning: Mum became friendly with a girl when they were in hospital together having the children. They have stayed in touch. This friend looks after X during the after school sessions. The friend takes her own little girl to the Sure Start mother and toddler club and

has offered to take X. with them in the mornings. Mum is happy about this and hopes X will enjoy making things. Although Mum has no experience of using Sure Start services with her own children, a little boy she used to look after went to a group some Sure Start workers visited, and he really enjoyed it.

Experience: X attended the mother and toddler group once a week for a few months. Mum felt it was very organised, from what she heard about it, and that X did many activities such as making books, and learning nursery rhymes.
Outcome: X enjoyed the group, Mum doesn't think he changed much due to going there and he stopped going when they moved as he now is looked after by a child minder. Mum and x have also attended other Sure start activities , namely the Christmas fair and the teddy bears picnic, which she heard about through letters sent to her in connection with her job at the school

Some things have changed since phase 1, mainly connected to the house move. X now is looked after by a child minder when mum works and he appears happy there. The child minder has told mum she feels X's speech is slow. Mum isn't worried but will watch the situation and take him to GP if necessary. Mum carries on taking him to other parent groups and also attends a mother and toddler swimming group some way off with him once a week.

Full summary Pt 17

Sure Start Counsellor.
Multi risk.
Poor environment.
Referred by health visitor

Back ground: Mum has been referred to a SS Counsellor. The family is a couple in a long term relationship, Mum's daughter – by another partner- attends primary school and the couple's son X. is eleven months old. The family live in a housing association house in a village in a deprived area of RCT. Dad works full time and Mum is a full time mother. Mum has obtained a law degree and would like to work. Mum has been feeling very depressed since X was born.

A typical day begins when X wakes in his own room. Mum hears him and she leaves him to play for a while, before she goes in about seven thirty. She changes him and brushes his teeth. He then comes down stairs and has breakfast with his sister. X may then accompany them on the school run or not, depending dad's work shifts. Then it's out to do chores such as shopping or going to the bank, and when they come home he has a sleep for an hour. When he wakes he gets his toys out, Mum doesn't think he plays much yet, just seems to chew toys. He seems quite happy playing by himself, but Mum gets down to play if she has the time. Then X has his lunch, usually sitting on his mums lap. After that mum does the house work and the chores. Then they leave to pick his sister up from school, and if his sister has things like swimming to do, they take her to them. When back home the children have dinner together, and then X goes to bed and settles himself to sleep. They do not use local activities and groups yet and Mum has not seen her friends much since she had X.

Experience of service use:
Beginning; Mum went into labour very early was admitted to hospital. Labour ended with a caesarean delivery. Mum didn't see X for 24 hours and he was kept in special care for 2 months. Mum suffered post natal infections, had further treatments and then spent all her time in the hospital with him, expressing milk and being there. Mum felt very upset about the whole process, felt she had not been consulted about the progress of labour, and was upset that she did not see X for so long afterwards even though all her extended family did. She has been having flashbacks about the birth and the arguments with the medical staff since this time. She discussed this with her Health Visitor who suggested she see the SS Counsellor to talk it through. Mum is relieved to be having this service as feels it will be good to have someone to talk to. The research assessments indicate X. is not developmentally delayed but many are near the borderline.

Middle: Experience: The first counselling appointment took a while to organise, as the first two were sent through the post, and were not convenient. The counsellor then sent her telephone number and Mum was able to ring and make a appointment she could keep. Sessions were once a week for twelve weeks at a local hospital. Initially, six appointments were offered and after these she was asked if she would like to carry on for another six which she did. A friend looked after X while mum was there, but this meant quite a few appointments had to be rearranged.

Outcome: Mum feels the sessions definitely made a difference, and said this was demonstrated by pre and post service assessment measures completed. She felt emotionally and physically stronger after using the counselling. This affected her relationship with the children as she felt she was more tolerant, and had the energy to spend more time playing with them. During the time of counselling Mum also went to the job centre organised some work experience and days in college. During this time X was given a place in Stepping Stones nursery which he loved. Mum said her work with the counsellor gave her continual emotional support throughout this time, support which she felt was not available elsewhere. Mum had heard something about other Sure Start services namely the toy library and the baby gym. She couldn't remember how she had found out about them but hadn't used them as didn't know where to find them and worried how much they would cost. The research assessments indicate that X's communication and problem solving skills are delayed. Fine and motor skills are near the borderline.

Changes have happened since the first study visit. Life has been difficult, and Mum's her relationship with X's father is breaking down. Mum wants to move the family to her own home town some distance away, and her partner won't go. Mum says he argues in front of the children, has left home before, and she threw him out yesterday. Mum is starting a new job in her home town next week, and has enrolled the children in schools and nursery there. She intends to commute until the Housing Association can move them. Mum feels all this has affected her daughter badly, she is not sure about X. She hopes the imminent move will be the start of a better life for her and the children.

Full Summary Pt 18
Referred by playgroup leader
Assisted places.

Low developmental risk
Pre-service good developmental environment.

Background: Mum has just been offered funding for her daughter's play group place, after the play group leader told her about the service and provided her with all the forms. The family is a single mother, with a teenage son and daughter by her first husband who Mum is now divorced from, and X who is her daughter from a later relationship which has broken down. The family live in a small, modern terraced house on an estate in a deprived area of RCT. Mum is a full time mother receiving invalidity benefit and is currently pursuing a degree.

X sleeps with Mum so a typical day begins they wake, and they have a bath together before taking the son to school. They then come home and sit and have breakfast together. They then feed the dog and the rabbit. Before X began play group last week X would then play with her toys, and then they would visit friends, but now she goes to her group. At twelve they come home and have lunch, usually a cooked lunch. If the weather is bad X might watch television or Mum will read her a book, X loves being read to. If it is nice they take the dog to the park, or over the mountain. At three o'clock they go and pick the other children up from school, then go home and make sure the elder two do their homework. There is a cooked dinner for all about 4.30 p.m, then Mum gives the older children lifts to friends, or their friends come over. X watches something on TV , they go on another dog walk, or visit friends. About eight o'clock X has a wash and puts her pyjamas on. She has supper with her sister, then X goes to bed with teddies and stories, and some song singing.

Experience of service use: The health visitor was concerned X was spending all her time alone with her Mum, and mum agreed as she felt X was becoming very shy and clingy. So Mum decided to enrol X in a play school, even though other family members were against the idea. Mum went to ask the play leader about X joining, and was told a space was available and that the fees were £20 a week. Then the leader enquired about Mums income, and when she heard Mum was on benefit, said that subsidies were available and gave her all the forms. Mum thinks she would have put X in any way, but not for so many sessions a week. Mum is hoping that the play group will help X become less shy, less clingy, and hopes it will give her a start in learning before she begins school. Apart from X being a bit clingy Mum has no concerns. The research assessments indicated no developmental delays.

Middle; X has been attending her play group for about eight months now. She still goes five days a week. Mum doesn't know exactly what she does there but she feels it is an organised group with many activities.

Outcome: Mum has noticed how X became much more confident since beginning school. it took about two months for this to become noticeable. X had been very shy at the start but after a couple of months was going in, saying hello and joining in. Mum also feels X has benefited educationally as she has learnt things at school that Mum had tried but failed to teach her at home. Mum is very pleased with the progress she has made, and says she would have paid for her to go anyway, but the funding has enabled her to send X

more often. X will finish playgroup soon and begin infant school. The research assessments indicated no developmental delays.

Outside of play school there have been lots of changes. Mum is in a new relationship and she and X spends 2/3 nights a week at his house. X plays with his children and mum feels this has helped her confidence. Mum has also begun a new part time job and given up her degree. This means X spends some evenings being looked after by family or by Mums' new partner.

Full Summary Pt 19

Parental direct request.
Sure Start Child Care Worker
Low developmental risk.
Good developmental environment.

Background. The family has been referred to a SSCCW because mum is worried about X's speech. The family consists of a married couple and their daughter X who is thirty six months old. Mum is about to have another baby. The family live in a modern, semi-detached house, in a nice area of a village near a large town. Both Mum and Dad work full time, and X. is looked after by her maternal grandmother when her parents are at work.

In a typical day X is up early and Mum takes her over to her grandmother's first thing, still in her pyjamas. Breakfast is alawys ready and Mum stays for ten minutes to see X settle, then she goes to work. Grandma gets X dressed and washed and does her hair, and then takes her up to nursery. In nursery they have singing, playing and snack, all sitting round a table. X. used to be very quiet with other children and let them take things she was playing with, but now she hangs on to her toys, and joins in with activities much better. At twelve the grandmother picks X up and they go up to her great grandmothers for lunch before back home where they play with things such as playdoh and crayons. Dad picks X up about half four, and by the time they get home Mum has tea ready and they all sit down together. Then it is about six, and all have an hours play together. X has a long bath every night, which she loves with bubbles and lots of toys. She doesn't come down again, she has milk and sometimes toast upstairs and then goes to bed and sleeps from eight until about seven the next day.

Experience of service use:
Beginning: X. begins school next month, and her mother is concerned about her speech. It is not that she doesn't talk, but she uses the wrong word, or says a made up word for something. Mum is not sure where or how she has picked up these words. Mum wants to know whether there is a problem or not and would like to know now, so if needed, therapy could be started as soon as possible X's grandmother thinks there is no need to consult anyone, but mum disagrees and contacted the Health Visitor, who suggested she referred X to the SSCCW. Mum thinks it is great to have somewhere to get this kind of help, and even if the SSCCW can't help they will have lost nothing. The research assessments indicated no developmental delays although her problem solving skills were on the borderline.

Experience: A SSCCW came for six weeks an hour each time. The arrangements were made to suit Mum. When the SSCCW came she brought activities, for example, one week she brought a house, another week a kitchen, she also used play activities such as colouring during which she talked to X as they played using words, that X couldn't pronounce, so X was hearing the word repeatedly. Mum didn't join in but she was listening, so she could pick it up to do later.

Outcome: X isn't talking more, she always talked a lot, but her words have become clearer and people can understand hat she is saying now. This has met Mum's concerns, and Mum is carrying on with it, if X has any trouble with a word Mum just uses it repeatedly with her. Mum says the service was worth having, although much of the service was common sense, but when the speech problem was going on she couldn't see a way out. Having the SSCCW provide the service was good, as it was something X. didn't mind doing it and loved being with the worker. Mum didn't know about Sure Start before and feels that not knowing where to go for help contributed to her worry about the speech problem. Mum has heard of further Sure Start services through her Health Visitor, her new baby had colic, the Health Visitor said baby massage helps and one morning she rang to tell Mum about a massage session, a taster morning. Mum went to it and to another five week course only twenty minutes away by car. Her SSCCW also told her about a SS Christmas fair, which Mum attended with a friend. Research assessments indicated her problem solving skills were developmentally delayed.

There have been other changes in the house since the first study visit. X. has had a baby sister, and has gone to full time school. This has been a big change because she goes at nine and is away all day, she comes home at twenty past three.

Full summary Pt 20.

Sure Start Health Visitor.
Low developmental risk.
Pre-service moderate developmental environment.
Direct parental request.

Background: The family have been referred to a SS Health Visitor because they are really concerned about X's eating. The family is a married couple with three children, X is their youngest child, he is four. The family recently moved to a terraced house, in the middle of a major town. Dad is a full time student and Mum is a full time mother.

Day from a developmental perspective:
A typical day begins when X wakes in the bedroom he shares with his brother. He gets dressed, come down stairs and has his breakfast. Breakfast has to be a yoghurt because X will eat that relatively fast. X takes a packed lunch to school, so Mum will know what/if he has eaten. Mum or Dad walk the children to school, and Mum picks them up at half past three. They come home and tea is served early because X takes so long to eat it, he can be at the table until six or seven o'clock. X goes to bed around seven but doesn't sleep straight away he has some time watching things, films, reading books, or playing. At the weekend they often go back to anearby city to see family, or the family visit

them. They haven't really got friends locally, and feel there are few places to take the children. The family does not have a car, and the children are sick if they go on a bus.

Experience of service use:
Beginning: Mum has been concerned about X's eating patterns since he was two. He was fine as a baby but now he eats a very limited range of foods and takes a long time over this. This means his evenings after school consist mostly of him sitting over his tea. X went to a dietician when he was living elsewhere but a family move to a town in another Health Authority area has meant Mum had to access services again. When they first arrived, the family registered with a local GP practice but the Health Visitor did not make contact, so Mum rang the surgery to ask for help. The first Health Visitor who came didn't put X on a referral list for help, but she recently left the new Health Visitor has referred X to a dietician and to a Sure Start Health Visitor. The family are waiting for her to visit and don't know what to expect. The research assessments indicate he has communication delay.

Experience: The SS Health Visitor came to the house once or twice before the generic Health Visitor took over. The SSHV asked the family to fill in forms, then she came and watched X eat. The family was advised to try X on different foods, only to give him half an hour to eat, give him pudding, a choice of things, and make sure breakfast, dinner, tea and supper were offered. The parents eat with them now.

Outcome: Mum doesn't think it worked at all, although they stuck to the plan which they have stopped now. Dad thinks it might have worked if they had carried it on longer as X was trying a few things he hadn't before. Another problem has emerged - the pattern of the food has become important and X will only eat if food is arranged properly. Overall, Mum feels it was worth having a go , as it was good to have a different option, and they got into a routine. However she feels X is exactly the same, but that she is more relaxed about it now. Dad feels X does eat faster because he doesn't have so long. The family is waiting to take X to see a dietician. The research assessments indicate X has no developmental concerns.

Full summary Pt 22

Sure Start Health Visitor.
Low developmental risk family.
Preservice good developmental environment.
Parental direct request

Background: The family has been referred to a SS Health Visitor as the whole family has been badly affected by X's sleeping problem. The family is a married couple, with two children. Their four year old daughter is at primary school and X. their son is ten months old. They live in a small poorly appointed housing flat in a RCT village farly close to the city. Dad works full time and Mum is a full time mother.

A typical day begins when the eldest child wakes about five o'clock, Mum gets up quickly with her even though she has always been up a lot of the night with X. X would

sleep a little longer, but as soon as mum stirs he wants to be up. He will start to play and plays with anything and everything. At this time his favourite is a cupboard door, and he will play happily for about an hour - usually round mum's feet. Then X is put into his highchair to have breakfast. Mum gives him finger food such as toast and she feeds him Weetabix. Then Mum gets him and his sister dressed, and they all walk to the school. This presents a problem as it is quite a long walk, and X will often have a little sleep in the pushchair which means he will not to sleep in his cot at home later that morning, which in turn means he is not as happy as usual for the rest of the day. Sometimes they call in the shops on the way home from school. When back home, mum tidies the house often with X on her hip. Some days they go to various local play groups. X's behaviour depends on the night before, but Mum tries to keep him going. At four o'clock it is school collection time, and when they return Dad is home. This is the worst part of the day as X and Mum are very tired by now and sometimes Mum lets X go to bed as his sister wants to tell mum about her day and gets upset if Mum can't give her that time. The children have their evening meal together about half four, and then they have a bath together, after which perks X up a bit. The family play together then for a little while, then it is supper, story – books are very important in this house - and bed by six thirty. X is asleep in 5 minutes but within an hour or two he is up again. If he is not up by half nine he will be up at two and by the time he wants to go to sleep again it is school time.

Experience of service use:
Beginning: X. has never been a good sleeper, he goes to sleep without any trouble, but will not stay asleep, he is up many times in the night and this has resulted in a very tired family. He has been like this from birth, by the time he was ten weeks old Mum felt terrible but when she mentioned it to her Health Visitor it was all contributed to the fact the baby was new and Mum was still recovering. When X was six months old Mum mentioned it to the GP, who thought she may have post natal depression, and gave her antidepressants, which Mum was unwilling to use. They tried everything they could but nothing was helping X sleep more. The family situation started to affect X's sister's progress at school and her teachers commented on her being tired. Mum felt her daughter was changing from being a lovely little girl to a right horror. Mum therefore approached the Health Visitor again, asked for help, and was referred to the SS Health Visitor. Mum feels they are desperate, but she had met another mother who had used the service, and been told that although it involved a very rigid sleep pattern the service had worked very well, so they are hoping it will work with a bit of determination. The research assessments indicated X's socio:emotional skills are delayed.

Experience: The SS Health Visitor came with the generic Health Visitor for the initial meeting. She asked the family to keep a sleep plan so she could see what the basic problem was. Then she came back, and working with the family routine, they constructed a plan together. She came back out a week later, went through it again, and asked about problems, or anything too difficult. The family then had to stick to the plan rigidly for one week. The SS Health Visitor gave Mum her telephone number and rang the family every single day. She told Mum if, after the first week or two, the sleeping plan wasn't working, she was willing to come to the house at bedtimes. The plan was quite simple. It did change the day slightly, before the children were having their tea about 4.30 p.m and then they bathed and then a story. The new plan made sure X went to bed first and was put to bed awake. For the first half hour the door was closed. The first three days were very hard , they had to go back in repeatedly to put him back down, but in the end he did

it himself. Mum hardly slept at all for the first thee nights but on the fourth day X just slept.

Outcome: Mum felt the service was fantastic, a lot of it common sense, but she got to the point where she was so exhausted, she didnt know what to do. She feels having someone else involved works, as it gives you a bit of confidence that you can do it, but on your own this can be too much. The family had the SS Health Visitor's number now, and any problems, and she will come. She plans to come and see him in six to twelve months just to see if he is OK. X's sister is doing well at school now. She's getting good sleep, and once she had caught up all was well. X's development assessments indicate no delay.

Follow up (one year later): Mum describes X as fine, but hard work The HV suspects he is suffering from a hyperactivity disorder, a problem his father has, which explains the sleep problem. Mum also feels it's a relief to have a sort of diagnosis. The HV has told her there is nothing that can be done until they are of school age, not even a proper diagnosis. In relation to the sleep problem within a fortnight the family was back to square one. Mum acknowledged that the program worked but didn't take into account, the living situations of people. In their case, she couldn't let X cry for 2 hours as they have his four year old sister in bed , a husband on shifts, and neighbours that can hear everything. X does sleep more easily but wakes 3 or 4 times a night and wakes mum and gets up. Overall mum feels the SSHV was fantastic but usually deals with children who have got into bad habits, not particularly with children with other factors that may affect their behaviour. Mum feels she is very lucky to have her health visitor, as she is very supportive. The family has come across no other SS services. There is little in her area and any parental support or socialisation seems generated by the local community here. Research assessments indicate X's socio:emotional and fine motor skills are delayed.

Other changes have happened, his dad has just got a new job, and Mum is starting as a teaching assistant soon, but no changes have impacted on the household yet..

Full summary Pt 23 and 24

Professional referral
Assisted places.
Multiple developmental risk
Pre-service poor developmental environment.

Background: The family have just been given funding for two playgroup places, after mum was told about service and given forms by playgroup leader. The family is a single young mother, with a son who has just begun secondary school and a twin son and daughter, who are thirty three months old. They live in a small modern HAS house, although the elder son often stays in the same village with his grandparents. The twins see their dad regularly but he does not live with the family. Mum has been suffering from depression for some time.

A typical day begins about half seven when the twins wake in their cot in the same room as Mum, before Mum does. They all get up and come downstairs for a drink of milk and some cereal, usually just the twins because their elder brother is at his Grandmas. The day is mostly based in the house, Mum finds it difficult getting around with two children

in the buggy, she doesn't drive and finds it too difficult to take both of them and the buggy on the bus. She does visit her Grandma, who lives in the same village with them, and had started going to a group for mothers with depression. When home Mum does the cleaning. The children do play a bit, but mostly watch television. They have lunch about midday and the twins then go to bed for an hour. In the afternoon, they watch television and play with toys, Mum tends to leave them to amuse themselves and feels there are few places to take them locally. Their brother comes home from school about 3.15 pm and watches television. Mum makes tea for the twins but their brother usually goes to his grandmas for tea. The twins then play until going to bed. Although Mum says they love stories and she does read stories to them sometimes. There is no real bedtime routine, sometimes they have a bath and after wards they settle themselves down.

Experience of service use:
Beginning: Mum can't remember where she heard about the assisted places scheme it was either from her Health Visitor or from a friend who told her about the playgroup. Where-ever she heard about it, Mum was very keen for the children to be able to go to playgroup as she is finding them very demanding at home, and suffers from depression herself. Mum went up to the play leader to enquire about places for the twins and was told places were available and they could start right away. However as Mum would have found the fees impossible, the play leader told her about the scheme and gave her all the forms. Mum feels she wouldn't have been able to send them to play school without the funding as the family is on income support and just couldn't have paid for them to go. Mum wouldn't have known about the service if the play leader hadn't said. Both twins assessments indicate developmental delays.

Experience: The twins started play school at the time of the first visit, and their day is now centred on play group as well as around the house. The children love play group, X runs in and give the teachers a hug and a kiss. Mum feels it is somewhere different for them to go, and they have both calmed down and are behaving better especially X. he goes straight in, and mixes straight away. The rest of the children's day has not changed. They still amuse themselves and watch a lot of television.

Outcome: Mum feels both children have calmed down, and that X is not as hyperactive or naughty as he used to be. Mum also feels the children have come on brilliantly in school. The activities they do at play school have not changed the things Mum does with them at home but Mum commented they have more ideas of things to do themselves at home since they began school, and she does sit and listen while they say what they have been doing at playgroup. Mum is however still finding Y difficult as she is demanding a lot of attention from mum in the house. Mum feels she has got her life back since play group began as she can do things such as visiting relatives or clean the house without them being involved. Mum said she felt much happier, better in herself. Mum had heard about another Sure Start services e.g. the toy library apparantly her Health Visitor told mum they took children on the bus and did things with them. Mum hasn't used it yet, she feels it is a lot of trouble to take the twins places. Neither child now shows socio-emotional delays but still have other areas of delay.

Changes have happened in the house make up as the elder son spends his time mostly home now, and the twins father is living at the home. No other changes have occurred
No other changes

Full service use Pt 25

Self referral
Toy Library.
Low developmental risk .
Pre-service good developmental environment.

Background: Mother and younger son signed up for the Toy Library service when it visited their play group. The family is a married couple with two sons. The older son is at primary school and X. their younger son is twenty seven months old. Dad works full time, Mum worked before she had X, but has been a full time Mum since. The family lives in a well decorated large detached bungalow in a deprived area of RCT.

A typical day begins with X waking about 7.30 am in his own room, he gets himself out of bed and calls for his mum, he won't go to his father at this hour. He has a bottle of milk, and then has his breakfast later, about nine o'clock. He brushes his teeth, and mum gets him dressed in the morning, then he watches DVD's. In the mornings Mum and X usually go to playgroup or go swimming with another friend, they also go to the nearby fields to see the horses, and go for a walk or take his bike down to the shop and the post office, They don't usually take the pram as X hates it. At lunch time he has things like chips, beans, fishcakes, sausages, and mum has a snack with him. Three times a week X goes to a playgroup in the afternoon where Mum leaves him, as she feels it is important to keep him busy because he is so active. After she picks X up they go and collect the older brother from school and the boys come home and have tea together. The brother usually goes out to play, but Mum and X stay in and X watches television, or he gets some toys out and plays, it depends on him, what he wants to do. X gets excited when daddy comes home, they play fight. Bath time is about six thirty and by eight X says bottle, bottle – because he likes to have his bottle to go to bed. Sometimes he has a story, it depends how tired he is.

Experience of Service use.
Beginning: Mum is very involved in activities and groups in the community. There are a lot of playgroups around but she chose to use this one because she knows all the other mothers there. The toy library moves around RCT and selected this play group to visit, Mum and X use it twice a week and happened to be there during the first visit. After the Toy library gave their talk about half of the mothers chose to enrol. Mum thinks it's nice to have new toys to use and feels it can help with their development. She is not sure what will happen next week. Research assessments show no developmental delays

Experience: The family carried on with Toy Library over the few visits it made, and took some more toys out, in fact they still have some because the woman didn't come back and get them.

Ending/Outcome: A jig-saw thing helped X learn all his colours quickly, but Mum doesn't think the service made any real difference to what they would have done anyway. Daily routine and activities is much the same , he goes up to the group now, three times a week..... in the afternoon, his grandma has him , and they do things at home, playing

and cutting at home and he loves cooking. He loves books has his story every night, and they go to a session up at the library. Research assessments show no developmental delays.

Full service use Pt.s 26 & 27

Self referral
Toy Library.
Low developmental risk
Preservice use good developmental environment.

Background: Mother and children signed the Toy Library service when it visited their play group a, by chance as it happened to be there. The family is a married couple with 2 children, X. their daughter is twenty seven months old, and Y a little boy who is twelve months old. Dad works full-time, and Mum part-time in a job which takes her away overnight sometimes. The family live in a semi-detached house, in a deprived area of RCT.

In a typical day Y gets up early – about 5 o 'clock and mum takes him into bed to get another hours sleep. Then they get up and come down stairs where he has his bottle. X usually comes down then and she too has a bottle of milk. They have a little table they sit at together to have breakfast, and then it is a rush on playgroup days to get out in time. If they don't go there they always get out, to shop or for a walk in the park, or to see her mother in law. Then it is home for lunch and afterwards Y has his nap. During this Mum and X have some time together, they often paint, or colour or play with plasticine. X is also good at playing by herself, Y is not good at being alone and will crawl after mum and cry. When he wakes mum must be free as he needs a cuddle for 15, 20 minutes when he wakes, then at 5 they have tea together. Mum baths them at six o'clock. She keeps to a routine, it is very important to her. The children get excited when daddy come home, they play more and wrestle and jump ' they get on the floor and they wrestle and jump on him...at the wrong time of day..... seven, seven thirty', about this time the children usually have a play and then they have a story and try and get them to bed.

Experience of service use:
Beginning: Mum uses the local play group, with her two young children, three times a week. The toy library moves around RCT and selected this play group to visit, the family happened to be there, they were not aware it was going to happen. After the Toy library gave their talk about half of the mothers chose to enrol and use the service, but she is not sure what will happen next week. Mum doesn't really know much about it, thinks it is quite nice but wasn't something she went to group particularly for. Research assessments showed no developmental concerns.

Middle: The family have just moved to a new house in the same village. They still go to play group. Mum felt the toys in toy library toys were good, especially the threading things...fruits and stuff. X loved that so much her parents went and bought something similar for her . Mum also felt it was also was nice to see new things.

Outcome, but mum feels the children have got so many toys and things at home, the service made no difference. Neither child showed developmental delay on research assessment.

Full Summary Pt 28

Sure Start Child Care Worker.
Low developmental risk family.
Pre-service moderate developmental environment. I
Indirect parental request.

Background: Family have been referred to a SSCCW as Mum is concerned about her son's behaviour. The family is a couple in a long term relationship with to children; a seven year old daughter and X. their son who is twenty-seven months old. They live in a terraced house in a deprived area of the county. Dad works fulltime, and Mum, part time in the evening.

In a typical day X wakes in his own room, around eight o'clock. He comes downstairs with Mum and has his breakfast with his sister. Then Mum helps him get washed and dressed, then - three days of the week - takes him to a playgroup where she leaves him for two hours. Mum feels that it is a lovely group, that X loves it and he has been doing well since he went there as it is a structured group, whose programme includes story time and songs and is Welsh speaking. If it s not a playgroup day, Mum won't go far with X and doesn't visit the shops or do anything she needs to do, she does what he wants, usually the park or swimming. She often stays home with him, as she finds it easier. At home he will play with his toys, particularly cars, or watch videos or TV. X lunches around half twelve, and then has a nap. They usually remain at home in the afternoon, friends don't tend to come over. About 3.00 they go by car to pick X's sister up from school Mum hates that as X undoes his seatbelt and climbs out of the car-seat. The children have tea together when they get home. At four-thirty Mum goes to work, and the maternal grandmother comes to look after the children. Grandma usually plays with the children but their activities are dictated by what X wants to do. Before bed X has a shower sometimes by himself and sometimes with his father, then he goes to bed. He used to settle himself to sleep but the last few weeks have been difficult, X's Dad slept with him one night and since then X has refused to settle, tries to come down stairs and screams for hours if this is not allowed.

Experience of service use:
Beginning: Mum had been having problems with X's behaviour. She was finding him hard to manage when she was by herself and felt he didn't listen to anything she said. Mum was particularly concerned about disobedience and tantrums. Mum mentioned this to her Health Visitor, who suggested referral to the SSCCW service. Mum had never heard about Sure Start but decided to give it a go, as she liked the idea of someone coming to the house to see the problem and provide some advice. Mum was hoping the service would result in a better, closer relationship between X and herself, and improve X's aggressive behaviours. Assessments show developmental delays.

Middle: The service began after contact was established by a telephone call. The SSCCW visited once a week for about 8 weeks. Sessions consisted of the worker and X sitting and playing games, lots of toys with different one's used every week. Mum thought the worker was fantastic and commented that X. loved the visits so much he would sit in the window waiting for the worker, but Mum feels it was not the service she thought it would be, she thought someone was going to come out and observe and advise on X's behaviours during the day's activities, not just work with him in the house. X's bedtime behaviour had not improved by the time service use began, and the SSCCW referred the family to a Sure Start health visitor, who visited and organised a sleep programme. This worked very well, as within a week X was in bed at the right time, stayed there and there have been no sleep problems since.

Ending/Outcome: Mum felt the work was really good, but not what she expected. Mum feels the service was inappropriate, that it was the wrong person in the wrong situation and problem behaviours such as Xreleasing himself from his car seat and climbing all over the car while Mum is driving have persisted. Mum does feel X has calmed down, and attributes this to the better atmosphere in the house now everyone is getting a good nights sleep. Mum felt the sleep service was very good and has recommended the sleep service to a friend.

Full summary Pt 29.

Talkabout.
Low developmental risk.
Pre-service good developmental environment.
Professional referral.

Background: The school has referred the family to Talkabout. The language and communication service is visiting the school and holding sessions for a group of children who teachers feel need some help with their language and communication. The family is a single young mother with two sons. The elder son is at the local junior school and the younger, X is forty eight months old. The family live in a modern, semi-detached house on an estate in a deprived area near a small town in RCT.

A typical day begins when X, who sleeps by himself, is woken around seven forty-five. Mum says he is dragged out of bed, comes down stairs, chooses his breakfast and eats it with his brother. X then washes and the family all brush their teeth together. Mum then walks the boys to school, which X attends from nine in the morning until ten past three in the afternoon. Mum picks him up, and then they go and wait for his brother to finish the junior school. They all come home, for the children have a snack and choose what they want for their tea. About five o'clock the grandparents come and pick them all up and they may go back to the grandparent's house for an hour, or go swimming or out somewhere else. Back home about six, for Mum and the boys to have a meal together and then it is bath time, followed by play which includes television, colouring and games. At eight o'clock, the television in his room is switched off and X goes to bed, he often has a story from his brother who likes to read to him. At the weekend they see mum's family, mums boyfriend and his family.

Experience of service use:
Beginning: X had just moved into the reception class at his local school. Mum received a letter, from the school, inviting her and X to come to some sessions, in the school, during school time, in which Sure Start experts were working with children and families to improve the children's language and communication skills. Mum felt the teachers thought some children would benefit from this input. Mum went to a meeting where the service was explained and has no qualms about attending, as she feels both she and X will enjoy, and benefit from it. Research assessments indicate X's fine motor skills are delayed.

Middle: Since the first study visit X has had multiple school based inputs from 'Language and Play', 'Start Right' and the Sure Start 'Talkabout' service. Talkabout was originally every Tuesday, for six weeks, in the morning from nine o'clock until half past ten/ eleven. Sessions varied depending on the things being made, this included making books, they made one with bits of Velcro in which they put the clothes on children figures, a nursery rhyme book, and a time book. During sessions workers came round, chatted, made sure everyone had everything needed, and saw how people were getting on.

Outcome: Mum feels X really enjoyed the sessions with the 'Talkabout' team at the school. She feels the service encouraged X to slow down when talking and consequently his pronunciation is much clearer now. He is also speaking more in the sessions because more people were coming up to him to talk. Mum felt she had benefited as she found X was more confident than she had previously thought, she also was able to see the little 'wobblies' X had when he wouldn't share. Mum liked having things to bring home, as they looked at them again and talked about them. Mum liked the fact the service gave you ideas of things to do at home, such as songs to sing which helped because the type of songs they picked seems to help with speech. She also liked having time to spend with X which was not spoilt by chores, interruptions, television or child concentration problems at home. Research assessments indicate X's communication skills are delayed.

There have been no other changes in the family since the last visit. Mum has no concerns about X.

Full summary Pt 30

Sure Start Child Care Worker & Sure Start Counsellor.
Preservice moderate developmental environment.
Low risk family but Downs syndrome baby.
Parental direct request.

Background: The family has been referred to the SSCCW and Mum to the SS Counsellor, because mum has asked the HV for help with the baby and for her anxiety and depression. The family is a married couple with one daughter X who is four months old and has Down's syndrome. They live in a small first floor flat in an area of deprivation near a RCT large town. Dad works full time and Mum is a full time mother.

In a typical day X wakes about seven thirty. Mum sleeps in the living room with her daughter, so dad can get a good sleep. Mum changes M's nappy and then gives her a bottle, she has fruit and cereal for breakfast an hour later. After dad has gone to work

Mum and X have a play. Mum works on motor movements, they cuddle, tell stories, sing, talk, watch TV, use the baby gym, and play with soft toys. Mum talks to X all the time. After the play X has a sleep, then a bath. During the day they often go for a walk in the pram, but only when the weather is good. Mum would like to find some groups to take X, as they are quite isolated with little support. Dad comes home about 5 o'clock, he has some time on the computer, Mum feeds X. Later Dad comes and takes the baby, he plays with her and feeds her sometimes.

Experience of service use:
Beginning: Mum had been trying to have a baby for 3-4-years, whilst she was pregnant she was told she was having a Downs baby. After the birth she felt she was having trouble coping and needed more support both emotionally and for herself as a parent, so she asked her generic Health Visitor for help. She was offered Sure Start or Home Start for support with the baby at home, and counselling sessions were also offered to give mum help for depression. Mum decided to use the Sure Start CCW and feels that was an easy decision, but felt a little awkward about the counsellor service. Mum is hoping for support, and having met the worker in an introduction meeting thinks she'll get it. She also hopes to gain new ideas of things to do with the baby. The visits to the counsellor she hopes will help her emotionally. Research assessments indicate X's motor development is on the competence line, otherwise no concerns.

Middle: The CCSSW came to the house and according to Mum has supported her through a lot of changes. Mum feels they didn't really teach her anything about parenting , but was someone there to talk to Mum, to see how X was developing and to chat about general things. The worker came twice a week for 12 weeks, and Mum feels it helped build her confidence up while she was going through a bad time.

Mum walks down to see the SS Counsellor at the hospital. She feels it is going to be worth while but lately has found it is getting her down. She is hoping this is things getting worse before better, but still gets good days. Mum doesn't know how long it long counselling will last, but feels she has to go because she need's help. Mum is about to use longer term help with Home Start which begins next week. The generic Health Visitor and the SSCCW have recommended Home Start and explained what will happen. The research assessments indicate X's motor development is on the competence line, otherwise OK.

Full Summary Pt 31 (field notes)

Talkabout.
Low developmental risk.
Pre-service moderate developmental environment.
Professional referral.

Background: Family have been referred to Talkabout, who are holding a language and play group at the school. The family is a married couple with two children. They live in a well presented modern semi-detached on a 'nice' housing estate on the outskirts of a small town. The son has a learning disability and attends an infant special school. Their

daughter X. is forty-eight months old and has recently begun the reception class at the local school. Dad works full time. Mum is a full time mother.

In a typical day X wakes in her parent's bed, she has her own room but usually ends up sleeping with her parents. X. gets up with Mum and has breakfast with her brother. After breakfast mum helps them both wash and get dressed. After her brother is collected by bus to attend his special school Mum takes X to school by car. After Mum has picked X up from school and both children are home after school, they have something to eat, watch television, play with their toys and look at their books Mum spends time playing with them this time of day, and helping X. use the computer. The family do not appear do much outside of the house, a couple of family outings to safari parks were mentioned, Mum said this was because X's brother likes animals. The children have a bath together and are read to or look at books in bed.

Beginning: Mum received a letter from school suggesting she and X attend the sessions to be run by Sure Start Talkabout, a language and communication group. Mum feels X has been offered this to compensate for any problems associated with having a brother with learning disabilities. Mum is happy to become involved because she feels it is too compensate and help, she hopes the service will help X's speech, cutting and fine motor skills. Research assessments indicate no developmental delays.

Experience: Mum and daughter took part in the Talkabout activity, Mum said this took place every other week through October to January. Both Mum and X. enjoyed the activities which included drawing, painting, cutting- out, and making things. The work was done together and also as part of the wider group.
Outcome: Mum described the service as very good, impressive. She feels it built-up X's confidence, and that they both now enjoy doing things together more, a factor which encourages X's talking. Mum would definitely recommend the services to others she feels it gave them confidence, and ideas of things to do at home. Mum has she has no concerns for her daughter. Research assessments indicate no developmental concerns.

Participant 32

Sure Start Care Child Worker.
Multiple risk factors
Pre-service poor developmental environment.
Professional referral.

Background: The family have been referred to SSCCW as the HV is concerned about the stimulation the baby is recieving. The family consist of an eighteen year old single Mum and eleven month old J. Mum is still in a relationship with X's father who often stays overnight but does not live with them. Mum is a young mother who has had long term contact with services particularly social services and mental health professionals as she has lived with depression for many years, and was brought up largely in care and experienced abusive relationships. The family recently moved to their current house to avoid a violent ex-partner.

In a typical day X. wakes between eight and nine o'clock. He sleeps in his own room, mum doesn't know when he wakes, but goes in when she hears noises. She brings him downstairs, and gives him a bottle of milk, after which he likes to play with his toys on the floor. A little later he has his breakfast, he sits in his baby chair for this and gets excited when he sees his food. After breakfast he plays on the floor again, then Mum gets him dressed and in the morning he plays with his toys by himself. He likes to play with the buttons on the TV, and he likes watching television - particularly when he sits on his Dad's lap. At lunch time X. has a jar of baby food, and then has his nap. He sleeps for about three hours. After this he has another bottle and a nappy change. X. has a bath every other day before bed. He loves baths especially when he has bubbles, no toys are put in the bath. X. is then put to bed, he doesn't like stories and settles himself to sleep. Dad works long hours, often from 5.00 am - 8.00pm, therefore when he comes over for the night he doesn't want to do much more than change, have his supper and watch television. Twice a week Mum takes X. by train to go shopping in nearby towns. She isn't keen on the area they live in and does not use many facilities. She did try the mother and toddler once, but has decided not to continue. Mum doesn't see many friends now and some days she is bored. Dad takes them to the supermarket once a fortnight, otherwise Mum uses a couple of local shops. Mum would like somewhere else to bring him up, and to have some transport, she feels they live 'in the middle of nowhere,' but that a move to another area is unlikely due to local authority housing availability, rent arrears, and because a violent ex-partner discovered the location of her last house.

Beginning: The input from SSCCW has been suggested by the HV who felt Mum wasn't playing enough with him, and X could do with some more stimulation. Mum was upset and angry about this as she felt the Health Visitor was unaware of the things they did with him. She doesn't really know what the service is however she hopes X will learn some skills from the service. She appears to have some negative feelings about the incoming service as she says she will 'Blank out' any stupid ideas the worker has. Research assessments indicate X has delays in fine motor and problem solving skills, with communication skills on the competence line.

Experience (telephone conversation): Mum had received 2 SSCCW sessions and then Mum says the worker stopped coming. In the sessions the worker and X did painting and drawing and X. had enjoyed it. Mum had not become involved mum but had watched. Mum's feelings about the service were mixed as she said she had done all the activities anyway, but also agreed the worker had given her ideas of things to do with X. Mum felt she had not stopped using the service, but they just kept missing each other, although she had not been unsure of the times the worker would be coming, and eventually the worker stopped coming.
Outcome: She felt the service had been worth having and she would have liked to carry on. She felt it had changed the stuff she does with him. Mum didn't contact the services to try and get them to come again, but didn't feel it was shyness or embarrassment, she just didn't. No research assessments were obtained

Things have changed since last contact. By six months after the referral to services, Mum had learnt to drive and moved to a much larger town which had pleased her. Mum felt she was better on the mental health front, as social services had helped her access further help. Mum and X. were also attending a crèche she found it through a cousin who lives

in her new town, a crèche in which Mum stays and does things with X and with a worker who helps.

Full Summary Pt 33

Sure Start Health Visitor.
Low developmental risk.
Pre-service good developmental environment.
Direct parental request.

Background: The family has been referred to the SS Health Visitor for help with their younger son's long term sleeping problems. The family are a married couple with two sons, the eldest has recently begun primary school and their youngest X is twenty-nine months old. They live in a modern mews house in a new gated development in and around an old hospital.

In a typical day, X. gets up 6-6.30 every day, this wakes his brother. The whole family goes downstairs for half an hour before going to get showered and dressed. The boys have their milk, and as X goes to a nursery 4 days a week mum will normally take him there. He has his breakfast at nursery, but will often eat a piece of fruit or toast on the way. He also has lunch there, as he stays until one. He loves it at nursery he has clingy moments, but also has a nice group of friends. He is picked up by his paternal grandmother- who used to run a nursery school herself. Grandma does a lot of cutting, painting, making things with X, she takes them both out and she is relaxed about mess in her house. Their grandfather, who suffers from depression is also there, and Mum feels having the boys around is good for him too. The grandparents take the boys out and go swimming once a week. X goes back to his grandparents house at one, and usually stays there until they go to pick his brother up at half past three after this time they may go back to Granny's or come back to their own house. Grandma gives them tea at 4.30, she sits and eats with them, she brings them back to the house before the parents come back. When mum and dad return they all have a quiet 'how did the day go' time. The boys then have their bath , and all go onto mum and dad's bed to watch a little TV and have milk, then bed with a story by seven. At the weekends they may do the big shop, go to the beach, play with their bikes in the enclosed grounds they live in, see friends- just spend time together.

Beginning: Mum and dad hade no concerns at all about X. apart from his difficulty sleeping. They asked their generic health visitor for help with this some time ago. She has been through all the basic steps with them and then said they needed to get someone else in. She suggested Sure Start as they had experts who deal with things such as sleep problems. Mum and Dad agreed because the situation was affecting their lives, both in attending work and in their own relationships. The parents have delayed input until after Xmas, as they know it is going to need regularity and commitment. They are looking forward to the help. Research assessments indicate no developmental problems or delays.

Experience; The SS Health Visitor came to see the family, asked them to keep a sleep diary and had constructed a sleep programme. Meantime, the parents had hoped they had sorted X's sleep by themselves, and so initially decided not to implement the sleep plan as this meant more changes. The SSHV therefore left the sleep plan with the family.X's new sleep pattern was disrupted by an illness that kept him awake. His sleep pattern did not become as bad as before but it did regress, so they decided it was time to to implement the sleep plan. Due to illness, a new SS Health Visitor came out and went through everything again, focusing on changing the order of their evenings, and good nights are rewarded by small presents, which has been a great motivator. They did not implement the stair gating on X's room unless they are desparate as they did not agree with this.
Outcome: This approach has helped, although things are not perfect X is a lot better, and the parents feel their night times are really different.X's day has changed a little as the first SS Health Visitor suggested they stopped preventing day time naps as he may be becoming overtired other wise the day structure is the same. The parents wish they had brought Sure Start in earlier. Looking back, they found the whole process quite difficult as they felt they were fairly well educated and had read about parenting techniques, couldn't understand why they were having difficulties. The SS Health Visitor reassured them saying it wasn't that their routine was wrong it was just not working for X. so changing it around may work. The parents felt happy they had used the service, had experienced it as supportive and flexible and felt it was ultimately their plan - a problem solving exercise to do the best for X. They had not felt stigmatised by it, although they discussed this quite a lot in interviews - as they just wanted a happy family. Research assessments indicate no developmental problems or delays.
Full Summary Pt 34

Sure Start Child Care Worker.
Low developmental risk
Pre-service moderate developmental environment.
Professional recommendation.

Background: The family have been referred to SSCCW by their generic health visitor, because Mum has been suffering from anxiety and depression since X's birth. Mum has been referred to a Sure Start counsellor. The family are a married couple, the father has two sons from aprevious marriage, and X is their baby daughter who is four months old. The family live in a large semi-detached house a village part of a large RCT town.

In a typical day, X. wakes at eight in the morning, having slept from eight the night before in a cot by her mother's bed. They have a cuddle in bed, then get up and come down stairs together as Dad has already gone to work. X. she has a bottle, and then her breakfast. Grandma either comes over then or they will go up to her house. Wherever they are, they play, read books, then around ten o'clock X has an hours sleep in her pram. When she wakes they have a cuddle, then a play before dinner. In the afternoon they may go shopping or to the park, as mum likes her to have fresh air every day. X then has tea and milk. In the evening X is very unsettled, and often has a bath with Mum or her father to try and keep her amused and happy. X has her final bottle and bed about eight.

Experience of service use:
Beginning: Mum has been having problems since the recent birth. She is finding X's crying impossible to cope with, is unable to stay in the house with X by herself and

therefore spends weekdays at her mother's house. Her Health Visitor was aware of the situation and recommended she used Sure Start child care worker service, and saw the Sure Start Counsellor. Mum had heard of Sure Start, but thought they just helped single mothers, with no money or family. Mum is hoping the SSCCW will teach her baby massage properly because that is known to soothe babies, she would also like to be shown how and what to play with M to keep her occupied. Mum had found it easy to agree to the referrals, but her mum and sister were horrified, Grandma can't imagine how anyone would want to have someone else come and show you how to play with your own children.

Experience: By the time of the second study visit Mum had been to see the Sure Start counsellor, The service had been provided in a hospital, and Mum had found that stressful, as the baby had to be left with Grandma and therefore Mum was worrying about her.
Outcome: Mum felt she couldn't talk to the counsellor her about feelings, and had not liked the service. She had persisted for four visits hoping it would get better, but still didn't like it and felt she was not making progress. Mum told her health visitor who wrote a letter cancelling the service, and Mum's sister rang the hospital and explained she wouldn't go again. The Health Visitor has now referred Mum to the community psychiatric team who will send their member of staff to the house, so Mum doesn't have to leave X.

Experience: The SSCCW came to the house with the generic health visitor to be introduced, and then came once a week for 6 to 8 weeks. Mum felt the worker had been great, and would have liked to continue receiving the service if she could have done, as she had found just knowing someone was coming for one hour a week had helped. During the sessions the worker sat on the floor for an hour and played with the baby. The SSCCW brought lots of activities; musical instruments, hand paints, animals, a calendar, numbers, a blow up ring. The activities were different every week. The SSCCW also brought leaflets with information which Mum found helpful as she wanted advice about child care and stimulation.

Perceived outcome: Mum felt the sessions gave her a break, especially when the baby cried and Grandma was not available. The sessions involved different activities and getting the baby down on the floor which was progress as before the visits Mum wouldn't let the baby go, but kept her on her lap. It also helped Mum become more relaxed about letting others have contact with the baby, before sessions Mm wouldn't let many others hold or play with X. Grandma had been impressed and said she had learnt things about child development she had been unaware of, she also felt the contact had been good for Mum, as Mum would listen to the worker but not to Grandma. Overall Mum felt the SSCCW service was good and had been worth having. The baby's activities have changed because the baby will sit and play with the toys now, and Mum feels more competent as before she didn't know what or how to do things with and for X. Mum feels much better than she did before this service and although she still visits Grandma daily these visits are shorter. Mum doesn't feels the counsellor service was right for her, but is happy further help is being provided but the community mental health team. Mum and baby now go to play group with her sister who was taking her son. She has been on her own once which she found stressful, but she persisted and she feels X. needs to be with other children.

Follow up:
Mum feels the SSCCW has had a lasting effect on the way she interacts with X. She would have loved to have the service longer but didn't feel she really needed it any longer. She has heard of one other SS service at the local library, Sure Start were doing stories or a language thing, and Mum arranged for her mother in law to take X. They found find out about it in the library when a lady said about it. Mum has seen the community mental health team - she had one appointment and never had to go again. It was brilliant, the worker told Mum she would get better, explained the panic attacks, and Mum felt that was what she needed. 'He sat me down and said this is what happening to you and you will get better.' He gave her a plan of action e.g. – go down to her mums quarter of an hour later and leave a bit earlier, and it all worked. The counsellor had told her she would never get better, that she had separation anxiety and this approach Mum felt was not for her. Mum attributes all the access and knowledge of different services to her HV, who still calls every couple of weeks to check things are OK, and has told mum to phone any time she needs her.

Since the last visit things have changed. Mum says she is better and has gone back to work at one of the local hospitals. She works two days a week and X is looked after by grandma one week and her other grandmother the week after. Mum says she wouldn't go to work otherwise. Nothing else has changed for X.